



ADDITIONAL QUALIFICATIONS Application Form

Please complete in BLOCK CAPITALS in black/blue ink. Make sure everything is legible as your membership details depend on it.

You can use this form to update your contact details if necessary—otherwise all you need do is fill in your name and address and Membership Number.

Name (Write your details CLEARLY in BLOCK CAPITALS)

Mr/Mrs/Ms/Other _____ First Name _____ Middle Name _____

Surname _____ Membership Number _____

Home Address in full _____

Home Tel. No. _____ Mobile No. _____

Name of Your Practice _____

Practice Address in full _____

Practice Tel. No. _____ Practice Fax No. _____

Website address _____ Email _____

The cost of adding EACH NEW THERAPY is €5 per therapy. There are **NO REFUNDS** so please make sure that your New Therapy is a valid stand-alone “complementary health therapy” and not just an “in house” module for a therapy which you have already been registered for. *If you are not sure, please ask your Trainer before submitting it to us.*

List the Therapy/ies which you wish to ADD to those already registered _____

On the attached page you **MUST** complete the information required for EACH THERAPY you wish to be registered for as otherwise we cannot process your application. (Please don't waste our time by listing any therapy for which you are not qualified)

Please tick whichever of these apply:-

I have insurance with the ARCHTI group scheme with Balens and I wish to ADD this new therapy/ies to my policy (please note that you will apply directly to Balens and that they may charge for this service)

I have insurance with another Insurance Company and I have already added this new therapy/ies to my existing insurance policy and **I am attaching a copy** of my insurance cert.

Name of Insurance Company _____ Policy Expiry Date _____

Signed: _____ **Date** _____

Official Use Only below this line.

Membership No. _____ Date received _____

Copy Insurance attached.....Yes/No. Expiry Date _____

Accepted: YES () NO () Signed: Membership Committee _____

Date: _____

- **If you need more space to list your therapies please copy this page and continue to list them—or you can ask us to send you additional pages.**
- **If your qualifications are not in the English Language please provide a certified translation of them.**
- **If your qualifications have been received from a non-English speaking Training Facility please contact them and have them provide you (or us) with information on who their training course is accredited by.**

Therapies for which you wish to register:

Therapy (1) _____ Qualifications Received _____

Length in Practice _____ Full or Part-time _____

College/Training Facility Attended NAME: _____

ADDRESS: _____

Tel No. _____ Fax Number _____

Email Address _____ Website Address _____

Therapy (2) _____ Qualifications Received _____

Length in Practice _____ Full or Part-time _____

College/Training Facility Attended NAME: _____

ADDRESS: _____

Tel No. _____ Fax Number _____

Email Address _____ Website Address _____

Therapy (3) _____ Qualifications Received _____

Length in Practice _____ Full or Part-time _____

College/Training Facility Attended NAME: _____

ADDRESS: _____

Tel No. _____ Fax Number _____

Email Address _____ Website Address _____

Therapy (4) _____ Qualifications Received _____

Length in Practice _____ Full or Part-time _____

College/Training Facility Attended NAME: _____

ADDRESS: _____

Tel No. _____ Fax Number _____

Email Address _____ Website Address _____

PLEASE ATTACH COPIES OF EACH QUALIFICATION—no need to take out of frame if copy is clear enough to read

PLEASE NOTE: any of the above details which cannot be verified by the Membership Committee or the Officers of ARCHTI will not be accepted for registration so it is up to the Applicant to provide as much detail as necessary in order to have their Therapy registered.