

Use this form to apply for membership with the Federation of Chinese Medicine & Acupuncture Societies of Australia Ltd (FCMA). PLEASE **PRINT**

PERSONAL INFORMATION								
Which State or Territory are you living? (<i>please tick one</i>) or Which country are your living?(for overseas applicant, please specify:_____)								
<input type="checkbox"/> VIC	<input type="checkbox"/> NSW	<input type="checkbox"/> QLD	<input type="checkbox"/> WA	<input type="checkbox"/> SA	<input type="checkbox"/> ACT	<input type="checkbox"/> NT	<input type="checkbox"/> TAS	
Title: (<i>please tick one</i>) <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss. <input type="checkbox"/> Dr. <input type="checkbox"/> Other ()		Given Name(s):		Surname:		Chinese Name (if applicable):	Date of Birth: (dd/mm/yyyy) / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
BUSINESS DETAILS								
Business Name (if applicable):				ABN: _____				
Address for your principal place of practice:			Suburb:		State:	Postcode:		
CONTACT INFORMATION								
Postal Address: (<i>if different from above</i>)			Suburb:		State:	Postcode:		
Home Phone Number: ()		Work Phone Number: ()		Fax Number: ()		Mobile Number:		
Email Address: (the FCMA strongly suggests you to provide an email address for efficient communication)				Address for second place of practice: (please attach additional sheet if there are more than two places)				
CHINESE MEDICINE BOARD OF AUSTRALIA (CMBA) DETAILS (Compulsory for applicant who applies for practitioner membership)								
Registration Number:		Registration Date: / /		Registered For: (<i>please tick all that applies</i>) <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chinese herbal medicine <input type="checkbox"/> Chinese herbal dispensing				
PROFESSIONAL INDEMNITY INSURANCE (Compulsory for applicant who applies for practitioner or remedial massage therapist membership with minimum \$5million and 2 reinstatements premium cover per year)								
Insurer:		Period of Cover: from / / to / /						
SENIOR/WORKPLACE FIRST AID CERTIFICATE (Compulsory for applicant who applies for practitioner or remedial massage therapist membership)								
First Aid Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Valid Period: from / / to / /						
EDUCATIONAL & PROFESSIONAL DETAILS (IF THERE IS NOT ENOUGH SPACE, ATTACH ADDITIONAL SHEET. PLEASE PROVIDE CERTIFIED COPIES OF YOUR QUALIFICATIONS AND ACADEMIC TRANSCRIPTS.)								
Qualifications: <input type="checkbox"/> Diploma <input type="checkbox"/> Bachelor <input type="checkbox"/> Master <input type="checkbox"/> PhD			Graduation Date:		Years of Full-time Study or equivalent:			
1. Acupuncture			/ /					
2. Chinese herbal medicine			/ /					
3. Remedial massage therapy <input type="checkbox"/> HLT 50302 or <input type="checkbox"/> HLT 50307			/ /					
4. Chinese herbal dispensing			/ /					
Name of University/College:								
Professional Experience: (<i>Number of years</i>)				Other Studies:				
Comments:								
VERIFICATION OF INFORMATION				Please affix one recent passport-size photo here.		OFFICE USE ONLY <input type="checkbox"/> CHM <input type="checkbox"/> ACU <input type="checkbox"/> MASSAGE <input type="checkbox"/> CHM DISP FCMA _____ Membership Number / / <i>Date of Approval</i> <input type="checkbox"/> Details Checked <input type="checkbox"/> Approved _____ President's Signature / / <i>Date Completed</i>		
I hereby verify that the above information is correct and up-to-date to the best of my knowledge and that certified copies of any relevant documentation to support my details are provided. If accepted as a member, I will abide by the Constitution of the FCMA and will at all times conduct myself and my practice in accordance with the ethical standards set by the FCMA.								
_____ <i>Signature</i>								
All related documents must be certified as true copies of the originals by a person authorised to do so (eg. a Justice of the Peace). Return Address: Please send the completed application form with all documents to the branch of FCMA where you are living.								

FCMA Membership Application Additional Form (Declaration)

Clause 12 of the FCMA Constitution empowers the Board of FCMA to determine whether or not to admit any applicant as a member. The Code of Practice developed by the FCMA provides guidance of the FCMA members with respect to the responsibilities of its members to their patients, the public and peers. Therefore, it is essential that only applicant who is fit and proper could be admitted to a member of FCMA. Please tick Yes or No on the following questions and provide details if the answer is "Yes".

1. Have you previously had application of membership by any Chinese medicine professional association refused?
 Yes No
2. Have you previously had any membership of a Chinese medicine professional association suspended or cancelled?
 Yes No
3. Have you previously been disqualified from applying for statutory registration of the Chinese medicine profession in Australia or other country?
 Yes No
4. Have you previously had statutory registration of Chinese medicine profession cancelled, refused or suspended in Australia or other country?
 Yes No
5. Have you ever had your provider rebate status refused or withdrawn by any private health insurance provider?
 Yes No
6. Have you ever been the subject of a complaint to any health complaints authority or association or similar?
 Yes No
7. Do you have, or have you previously been diagnosed with, a health related condition that might impact negatively on your responsibilities to patients, including alcohol abuse or drug-dependency?
 Yes No
8. Do you have any criminal history in Australia or in another country?
 Yes No

Name of applicant: (please print) _____

Signature of applicant: _____

Date of signature: _____