APPLICATION FOR ASSOCIATE MEMBERSHIP

2017

MEMBERS A candidate for admission to Associate Membership of the Institute of Chiropodists and Podiatrists must possess the qualifications required by the Articles of Association. The application must be made in writing and addressed to the Secretary of the Institute on the form prescribed in the appropriate schedule of the Bye-Laws.

Applicants must:

(a) Satisfy the Board of Education of the Institute that he/she is of good character. (b) Satisfy the Board of Education of the Institute that he/she is in good health, both physically and mentally. (c) (i) Satisfy the Board of Education of the Institute that for a period of at least three years (which need not be continuous) he/she has spent a substantial part of his/her working life (80%) in the lawful, safe and competent practice of foot health. If asked to do so, candidates must produce satisfactory evidence; or (ii) Have completed a course of study recognised by the Board of Education of the Institute. (d) If required to do so by the Board of Education of the Institute, pass:(i) The prescribed test of competence; or (ii) Such part of that test as the Board of Education of the Institute may specify.

DESIGNATORY LETTERS An Associate may use after his/her name the initials "A.Inst.FHP", but any person who has for any reason ceased to be an Associate shall not after the date on which he/she ceases, describe or in any way refer to himself/herself as an Associate or member of the Institute, nor use any words or letters representing himself/herself to be an Associate or member, nor shall he/she refer in any professional announcement to his/her past connection with the Institute as an Associate or member.

The Associate Certificate must be returned to the Institute on cessation of Membership.

PLEASE COMPLETE IN BLOCK LETTERS

Title: Mr / Mrs / Ms / Miss (delete not applicable)

Surname:

____

Forename(s):

____

Date of Birth:

____

The Institute of Chiropodists and Podiatrists, 150 Lord Street, Southport, PR9 0NP
www.iocp.org.uk secretary@iocp.org.uk 01704 546141

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Address:

____

____

____ Post Code: ___________________

Telephone: (Including Area Code)

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Mobile:

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Email:

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Professional qualifications

Qualifications currently held:

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____

Where did you receive your training?

____ (Please enclose copies of your training/CPD certificates where applicable)

How long have you been practising?

____

Practice details

Particulars of Practice: (delete not applicable) Surgery only / Surgery & Domiciliary / Domiciliary only

Practice / Employer's Name:

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Practice Address: ____

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____ Post Code: ____________

Telephone: (Including Area Code)

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Insurance & Ethics

Do you currently hold Professional Indemnity insurance cover? Yes:□ No:□

Whilst in practice, have you had any insurance claims made against you? Yes:□ No:□ If 'Yes' to the above, do you have any insurance claims pending? Yes:□ No:□

Have you ever been refused insurance cover to practice foot healthcare? Yes:□ No:□

Have you ever been disciplined or declined membership of any other organisation? Yes:□ No:□ (If yes you will be asked for further information)

If required to do so would you be prepared to sit a prescribed test of competence? Yes:□ No:□

Do you belong to any other professional organisation? Yes:□ No:□

If 'Yes' to the above, please give details below:

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Please hand the enclosed reference forms to your chosen referees and return with your completed form