APPLICATION FOR ASSOCIATE MEMBERSHIP

The Institute of Chiropodists and Podiatrists

Application for Associate membership (for Foot Health Practitioners)

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 recognized 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 "AInstFHP", 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 THIS FORM IN BLOCK LETTERS

APPLICATION FOR ASSOCIATE MEMBERSHIP

The Institute of Chiropodists and Podiatrists

Personal information:

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

Surname: _____

Forename(s): _____

Date of Birth: _____

Address: _____

_____

_____ Post Code: _____

Tel. *(Inc. Area Code)*: _____ Mobile: _____

Email: _____

Professional qualifications:

Qualifications currently held: _____

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: *Surgery only / Surgery & Domiciliary / Domiciliary only *(*delete not applicable)*

Practice / Employer's name: _____

Practice address: _____

_____

_____Post Code: _____

Telephone *(inc. Area Code)*: _____

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 you've answered 'yes' to the above, do you have any insurance claims pending?	Yes ☐	No ☐
Have you ever been refused insurance cover to practise foot health care?	Yes ☐	No ☐
Have you ever been disciplined or declined membership of any other organisation? *(If you've answered 'yes' you will be asked for further information)*	Yes ☐	No ☐
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?	Yes ☐	No ☐

If you've answered 'yes' to the above, please give details below:

_____

_____

_____

_____

_____

_____

_____

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

Fees:

Fees are only payable after your membership application has been accepted

Annual Subscription: £245.00 [2017] ***plus*** £25.00 compulsory administration fee

Optional Insurance:

Option 1 Basic insurance as per summary of cover: £133.54 [2017]

- Details of the Insurance are contained in the enclosed Summary of Cover.
- Members not joining the Institute's Insurance Scheme, are required to furnish proof of insurance.
- Fees are payable on acceptance and thereafter on 1st January each year.
- You must advise us of any material facts that may affect your cover - if you are in any doubt about whether facts are material, you must inform us - failure to do so could affect the validity of your policy.

APPLICATION FOR ASSOCIATE MEMBERSHIP

The Institute of Chiropodists and Podiatrists

Declaration:

To the Executive Committee of The Institute of Chiropodists and Podiatrists,

Having duly read and understood the qualification for Membership and the Ethical Rules and completed the attached Schedule, I wish to apply for admission as an Associate of The Institute of Chiropodists and Podiatrists, in accordance with the Memorandum & Articles of Association and the Bye-Laws, Rules and Regulations thereof for the time being in force.

I hereby undertake not to engage in advertising outside of the regulations currently permitted by the Board of Ethics *(details of which are contained in the Bye-Laws)*.

Should my application be accepted, I do solemnly declare that, as an Associate of The Institute of Chiropodists and Podiatrists, I will observe the conditions of the Memorandum & Articles of Association and Bye-Laws of the Institute, Ethical and other Rules and Regulations thereof; and I will conduct myself honourably in the practice of the profession, and maintain the dignity and welfare of the Institute.

I certify that I do not suffer from any physical or mental condition that could adversely affect me from safely and competently practising foot health. I declare that to my knowledge, I do not suffer from any condition or illness that may be contracted by, or be a danger to, a third party.

I warrant that my answers to the attached questions form the basis of my application for Associate membership and that any error shall entitle the Association to refuse to admit me or to cancel my membership if any error shall be ascertained subsequently to my having been admitted to membership.

Applicant's signature: _____ Dated: _____/_____/_____

Witnessed by (name): _____

Occupation: _____

Address: _____

_____

Signed: _____ Dated: _____/_____/_____