



# APPLICATION FOR MEMBERSHIP

The Institute of Chiropodists and Podiatrists

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## Application for membership (for HCPC Registered practitioners)

**Members:** A candidate for admission to 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) Have completed a course of study recognised by the Board of Education of the Institute.
- d) Be a Registered Chiropodist/Podiatrist (be registered on the Chiropodists and Podiatrists part of the Health Professions Council Register or be Registered with the Department of Health in the Republic of Ireland).

**Designatory letters:** A Member may use after his/her name the initials "MInstChP", but any person who has for any reason ceased to be a Member shall not after the date on which he/she ceases, describe or in any way refer to himself/herself as a Member of the Institute, nor use any words or letters representing himself/herself to be a Member, nor shall he/she refer in any professional announcement to his/her past connection with the Institute as a Member.

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

\*PLEASE COMPLETE THIS FORM IN BLOCK LETTERS



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## **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:**

HCPC Registration number (DOHI in the Republic of Ireland): \_\_\_\_\_

Where did you receive your training? \_\_\_\_\_  
*(please enclose copies of your training / CPD certificates where applicable)*

How long have you been practicing? \_\_\_\_\_

## **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)*: \_\_\_\_\_



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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 you've answered 'yes' to the above, do you have any insurance claims pending? Yes  No

Have you ever been refused insurance cover to practice chiropody / podiatry? 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 chiropodial / podiatric organisation? Yes  No

If you've answered '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.*



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## **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:**

<u>Option 1</u>	Basic insurance as per summary of cover:	£133.54 [2017]
<u>Option 2</u>	Basic insurance <b>plus</b> cover for Aromatherapy and/or Reflexology and/or Acupuncture (below the knee only):	£133.54 [2017]
<u>Option 3</u>	Basic insurance and/or above <b>plus</b> cover for Laser Therapy:	£194.04 [2017]
<u>Option 4</u>	Basic insurance and/or above <b>plus</b> Local Anaesthesia by injection and/or Invasive Surgical Procedures and/or Prolotherapy and/or Vesalius Bladion Molecular Resonance Generator Surgery Devices and/or Prescription Only Medicines and/or Antibiotic Administration and/or Steroid Injection Therapy and/or Diagnostic Ultrasound and/or Cryoanalgesia Treatment and/or Silicone Injections and/or Joint Mobilisation Techniques up to the Tibia Femoral Joint:	£199.54 [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.



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## **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 a Member 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 a Member 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 podiatry. 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 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: \_\_\_\_\_

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Signed: \_\_\_\_\_ Dated: \_\_\_\_/\_\_\_\_/\_\_\_\_