



MEMBERSHIP APPLICATION FORM

"Wellness is a lifelong process of assuming personal responsibility that empowers the individual to exercise choice, make informed decisions and take action towards a more balanced, dynamically sustainable and fulfilling existence in all dimensions of life"

A.

SURNAME	GIVEN NAMES	TITLE	D.O.B.
RESIDENTIAL ADDRESS		STATE	POSTCODE
HOME PHONE No.	MOBILE No.	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED NAME OF SPOUSE	

PREFERRED EMAIL ADDRESS:..... Email addresses are published in the CAA National Contact Directory and on the CAA SA members only section of the website please circle your preference for the following options:

Publish in CAA member directory YES / NO Allow on CAA SA members section YES / NO

LANGUAGES SPOKEN:

IF YOU ARE NOT A PERMANENT RESIDENT PLEASE GIVE DETAILS OF APPLICATION FOR PERMANENT RESIDENCE	
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The clinics shown in this section will be used for membership directory listings.	
MAIN CLINIC ADDRESS Building Street Town State Postcode Phone No's: Fax No: Work Hours: Office Email: DVA <input type="checkbox"/> MAC <input type="checkbox"/> EPC <input type="checkbox"/>	SECOND CLINIC ADDRESS Building Street Town State Postcode Phone No's: Fax No: Work Hours:..... Office Email: DVA <input type="checkbox"/> MAC <input type="checkbox"/> EPC <input type="checkbox"/>
THIRD CLINIC ADDRESS Building Street Town State Postcode Phone No Fax No.Wk Hrs:	PREFERRED POSTAL ADDRESS Building Street Town State Postcode

B.

Please indicate in which category you are applying for membership:

- Fully practising member
- Limited / Part time practitioner (incl. Statutory Declaration) * *:
 - No. of hours practised per week:(<12hrs)
- Concessional member: State full date of graduation:
- Non practising member (incl. Statutory Declaration) * *
- Full time academic (incl. Statutory Declaration) * *
 - Give details:
- Interstate Associate: State primary branch of membership:
- Foreign Associate: Give details of workplace
- Foreign Student: Give details of Chiropractic College / Institution

****NB: A Statutory Declaration is required if you don't practice in excess of 12 hours per week.**

- Are you transferring from another Branch? Which Branch?
- Are you a member of another Branch/es? Give Details: Branch: Status:

C. CHIROPRACTIC QUALIFICATIONS / AWARDS

INSTITUTION	AWARDS / QUALIFICATIONS OBTAINED	GRADUATION YEAR

OTHER QUALIFICATIONS / AWARDS

INSTITUTION	AWARDS / QUALIFICATIONS OBTAINED	GRADUATION YEAR

D. DETAILS OF PROFESSIONAL REGISTRATION OR LICENSES (include X-ray)

REGISTERED OR LICENSED AS	COUNTRY/STATE	LICENSE NO.	YEAR GRANTED	CURRENT	EXPIRY DATE

E. DETAILS OF MEMBERSHIP TO PROFESSIONAL ASSOCIATIONS

NAME OF ASSOCIATION	COUNTRY/STATE	YEAR GRANTED	CURRENT	EXPIRY DATE
HAVE ANY OF YOUR PROFESSIONAL REGISTRATIONS OR LICENSES OR MEMBERSHIPS EVER BEEN REFUSED, REVOKED OR SUSPENDED? IF 'YES' GIVE DETAILS		[YES] _____ [NO] _____		

F. DETAILS OF PAST CLINICAL EXPERIENCE - INCLUDE LOCUMS (if same as current go to G)

FROM	TO	PRACTICE ADDRESS	Part-Time	Full-Time	Self-Employed	EMPLOYER'S NAME

G. DETAILS OF CURRENT CLINICAL ACTIVITY

PRINCIPAL PRACTICE Date Commenced: / /

BUSINESS NAME IF ANY AND NAME OF EMPLOYER IF NOT SELF	PHONE NO.
PRACTICE ADDRESS	STATE P/CODE

OTHER PRACTICE Date Commenced: / /

BUSINESS NAME IF ANY AND NAME OF EMPLOYER IF NOT SELF	PHONE NO.
PRACTICE ADDRESS	STATE P/CODE

	CHIROPRACTIC TECHNIQUES	SOFT TISSUE	SKILLS	EQUIPMENT USED	DO YOU ADVERTISE?																														
<input type="checkbox"/> PRINCIPAL PRACTICE <input type="checkbox"/> OTHER PRACTICE	<table border="1" style="width: 100%; text-align: center;"> <tr><td>ACTIVATOR</td></tr> <tr><td>AK</td></tr> <tr><td>COX</td></tr> <tr><td>CRANIAL</td></tr> <tr><td>DIVERSIFIED</td></tr> <tr><td>EXTREMITY</td></tr> <tr><td>GONSTEAD</td></tr> <tr><td>McMANUS</td></tr> <tr><td>NET</td></tr> <tr><td>SOT</td></tr> <tr><td>THOMPSON</td></tr> <tr><td>TMJ</td></tr> <tr><td>TRIGGER POINT</td></tr> </table>	ACTIVATOR	AK	COX	CRANIAL	DIVERSIFIED	EXTREMITY	GONSTEAD	McMANUS	NET	SOT	THOMPSON	TMJ	TRIGGER POINT	<table border="1" style="width: 100%; height: 40px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>						<table border="1" style="width: 100%; text-align: center;"> <tr><td>Pediatrics</td></tr> <tr><td>Sports Injury</td></tr> <tr><td>Elderly</td></tr> <tr><td>Animal</td></tr> </table>	Pediatrics	Sports Injury	Elderly	Animal	<table border="1" style="width: 100%; text-align: center;"> <tr><td>XRAY UNIT</td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>	XRAY UNIT				<table border="1" style="width: 100%; text-align: center;"> <tr><td>SIGN</td></tr> <tr><td>NEWSPAPER</td></tr> <tr><td>PHONE DIRECTORY</td></tr> <tr><td>OTHER</td></tr> </table>	SIGN	NEWSPAPER	PHONE DIRECTORY	OTHER
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PLEASE LIST CHIROPRACTIC IN ORDER OF PREFERENCE
ie: 1, 2, 3 etc.

SKILLS AVAILABLE AT MAIN CLINIC

PHYSIOTHERAPY	ACUPUNCTURE
NATUROPATHY	MASSAGE THERAPY
OTHERS :	

DETAILS OF PROFESSIONAL EMPLOYEES OR ASSOCIATES

SURNAME NAMES	GIVEN	QUALIFICATIONS	REG. NO.

H. IF 'YES' GIVE DETAILS

ARE YOUR CLINICAL PREMISES USED FOR ANY	[YES]
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ACTIVITY OTHER THAN THOSE DESCRIBED ABOVE?	[NO]
HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE? IF 'YES' GIVE DETAILS	[YES]
	[NO]
HAVE YOU EVER PRACTISED IN ANOTHER STATE OR TERRITORY? IF 'YES' GIVE DETAILS	[YES]
	[NO]
HAVE YOU EVER BEEN DISCIPLINED BY A PROFESSIONAL ASSOCIATION OF WHICH YOU WERE A MEMBER?	[YES]
	[NO]
HAVE YOU HAD OR ARE YOU AWARE OF ANY MALPRACTICE CLAIMS AGAINST YOU?	[YES]
	[NO]

DECLARATION BY APPLICANT

I agree to abide by the Code of Ethics of the Chiropractors' Association of Australia (SA) Ltd and to observe all rules and regulations within the Constitution, Memorandum and Articles of Association plus By-Laws and any amendments that are made thereto from time to time. This embraces paying all fees outstanding up to the time of ceasing membership.

I agree to uphold the principles of the Association and to assist in all ways to accomplish its objectives.

I hereby declare that all information given in the application and in the accompanying documents is true and I understand that any misrepresentation on my part willful or unintentional, may cause me to forfeit my membership of this Association.

SIGNATURE OF APPLICANT..... Date

SIGNATURE OF WITNESSDate.....

ANOTHER PRACTISING CAA MEMBER TO COMPLETE BELOW

The above applicant is personally known by me:

PROPOSED (PLEASE PRINT)

SIGNATURE Date

PLEASE RETURN COMPLETED FORM AND ANY ADDITIONAL PAPERWORK TO

CAASA GPO BOX 2407 ADELAIDE SA 5001

P: 08 8336 7562 F: 08 8365 8456

OFFICE SUMMARY			
Date Received	Date Executive Approval
Details Checked	Date HQ Informed
Date:Letter to Applicant		