VIC BRANCH
PO Box 13163, Law Courts VIC 8010
40 Dudley Street,
West Melbourne, VIC 3003

T: 03 9328 4699
F: 03 9328 2966
www.caavic.asn.au

ABN 28 050 191 967

MEMBERSHIP APPLICATION FORM

Surname: ....

Given Names: ....

Date of Birth: .... Sex: M / F *(please circle)*

Are you a: ☐ Locum ☐ Associate ☐ Principal ☐ Other ....

Are you transferring from another Branch: YES/NO If Yes, Branch:.............

Contact Details:

Private Address Postcode		Phone: Fax: Mobile:
Postal Address Postcode		
Clinic Name & Practice Address/es 1. Postcode	☐ X-ray ☐ Disabled Access	Phone: Fax: A/H Emergency:
2. Postcode	☐ X-ray ☐ Disabled Access	Phone: Fax: A/H Emergency:
3. Postcode	☐ X-ray ☐ Disabled Access	Phone: Fax: A/H Emergency:

Clinic Website Address: ____

Clinic Email Address: ____________________________________ ☐ preferred email contact

Personal Email Address: __________________________________ ☐ preferred email contact

The Branch sends out emails from time to time to notify of legislation changes, CA Award updates, job opportunities, seminars, etc. The Branch will ***not*** *forward your email address to a third party.*

Please indicate in which category you are applying for membership:

☐ Student – Please tick year of study: 1st year ☐ 2nd year ☐ 3rd year ☐ 4th year ☐ 5th year ☐

Institution attending ....

☐ Standard Year 1 Member *[first year of practice]*

☐ Standard Year 2 Member *[second year of practice]*

☐ Standard Year 3 Member *[third year of practice]*

☐ Standard Year 4/Full Time Member *[fourth year and thereafter]*

☐ Limited (part-time) Member - Indicate number of hours practiced per week: ....

☐ Non Practising

☐ Retiree (Over 55 years of age/20 years membership/spec circumstances)

☐ Academic - Give Details ....

If practising Part-Time, indicate N° of hours practised per week: ....

☐ Foreign Associate

Primary chiropractic qualifications: ....

Institution: .... Year granted: ....

Other academic chiropractic awards:

Award: .... Year granted: ....

Institution: ....

Tertiary/post-secondary awards in other disciplines:

Qualification: .... Year granted: ....

Institution: ....

STUDENTS – go to Declaration by Applicant – Page 4

DOCTORS ONLY - **Please complete the following section relating to registration licensure:**

Chiropractic Practice:

AHPRA Registration no: .... Date registered: ....

X-ray:

State/s:... Licence no:...................... Date registered: ....

Other professional/paraprofessional registration/licensure:

Discipline: .... Jurisdiction: ....

Please list chiropractic experience (including locums):

Location:... Dates of Practice ....

....

....

....

What **languages** (other than English) are spoken in your clinic? ....

What techniques are you skilled in and use in your clinic?
*(please tick **a maximum of five** only)*

☐ Activator ☐ Applied Kinesiology ☐ Cranial ☐ Chiropractic Biophysics

☐ Chiropractic Ecology ☐ Diversified ☐ Drop Piece

☐ Gonstead ☐ Flexion Distraction ☐ Logan Basic ☐ Manual

☐ Network Spinal Analysis ☐ NET ☐ Neuro Impulse Protocol

☐ Nimmo ☐ SOT ☐ Soft Tissue ☐ TBM ☐ Thompson ☐ Toggle Recoil

☐ Torque Release ☐ Trigger Point ☐ Webster

What adjunctive therapies do **you** use in your clinic?

☐ Nutrition ☐ Acupuncture ☐ Naturopathy ☐ Homeopathy ☐ Psychology/Counselling
☐ Massage ☐ Other – please specify ....

What areas of special interest do **you** have (if any)?

☐ Sports Chiropractic ☐ Paediatric Chiropractic ☐ Rehabilitative Chiropractic
☐ Animal Chiropractic ☐ Chiropractic Neurology
☐ Other – please specify ....

Details of further studies you have completed in these fields: ....

Do you accept patients for:
☐ Department of Veterans' Affairs (DVA)
☐ Transport Accident Commission (TAC)
☐ WorkSafe (previously WorkCover)
☐ Comcare

Do you accept Medicare Enhanced Primary Care (EPC) Referrals? Yes / No

If *Yes*, do you: ☐ Bulk bill *or* ☐ Bill the patient

Do you have x-ray facilities in your clinic which **you** use? Yes/No

Do you provide after hours/emergency care at your clinic? Yes/No

Emergency Contact Number (available to patients): ....

Have you been disciplined by a professional association of which you were a member?

Yes / No   If yes, specify:..

Have you had or are you aware of any malpractice claims against you?   Yes / No
If yes, specify: ....

....

....

Have you ever been prosecuted?   Yes / No
If yes, specify: ....

....

....

DECLARATION BY APPLICANT

I agree to abide by the Code of Ethics of the Chiropractors' Association of Australia (Victoria) Limited and to observe all rules and regulations within the Memorandum and Articles and By-Laws and any amendments that are made thereto. Membership is continuous until one month's written notification is provided to the state branch. http://www.caavic.asn.au/home/about-caa

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

I agree to pay all dues of the Association and to assist in all ways to accomplish its objectives.

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

Signature of applicant: .... Date: ....

Signature of witness: .... Date: ....

☐ I have enclosed a current photograph

$100 Application fee to accompany all membership applications (except students)
The application fee will be subtracted from the total of your membership fee.

☐ I have enclosed a cheque for $100 *(please make cheque payable to* ***CAA (National) Ltd***

Or

☐ Please debit my credit card: ☐ Visa ☐ Mastercard

Card Number: __ __ __ __/ __ __ __ __/__ __ __ __/__ __ __ __

Expiry: __ __/ __ __   CCV No __ __ __ __

Name on Card: ....

Signature: ....