

Membership Application Form



Name	
-------------	--

Address	
----------------	--

Tel. Numbers	
---------------------	--

Social Media Addresses	
-------------------------------	--

Email & Website	
----------------------------	--

Therapies Practiced	
----------------------------	--

Locale of practice	
---------------------------	--

Professional Associations	
----------------------------------	--

Professional Indemnity Insurer	
---------------------------------------	--

Qualifications	Place of Study	Date Qualified

Current Training	
-------------------------	--

Do you practice full-time/part-time	
--	--

What do you hope to gain from the network?	
---	--

What would you be able to contribute to the network?	
---	--

Would you be interested in attending and/or contributing to workshops? If so, what subjects would interest you?	
--	--

At the initial meeting of the Sutton Complementary Health Network, held on 5th October 1998, The Committee agreed that it would be responsible for implementing and ensuring that members abide by the following policy and objectives:

- Work to promote a closer working relationship between modern (allopathic) medicine and complementary therapists
- Increase contact and cooperation between practitioners of different therapies
- At our AGM held on 16th May 2018, the Committee agreed that members would be expected to attend, as a minimum, three meetings per year and one external event

The keyword of the Network is “cooperation” in its dealings with everyone involved with healthcare.

The network recognises the Equal Opportunities legislation and will take positive steps to ensure that its members do not discriminate on the basis of race, disability, gender, sexuality, social class, HIV, age, religion or caring responsibilities.

I agree to abide by the policy and objectives of The Sutton Complementary Health Network and by my Professional Code of Ethics. I understand that my membership may be reviewed if my attendance falls below that expected.

Signed _____ Date _____

I enclose copies of my professional qualification certificates, insurance certificates/proof of insurance via professional association memberships and my membership fee.

Annual membership fee of the Network is £60.00 (pro –rata on a monthly basis from a renewal date of April 1st) with a one off joining fee of £20.

It is the responsibility of the Therapist to make sure the professional indemnity insurance is always up to date and to provide a copy thereof with the renewal fee.

Please return to Membership Secretary by post or email copy:

Katie Nunn, 51 West Street, Sutton, SM1 1SJ

Tel: 07773 466229

katiennun@hotmail.com / info@schn.org.uk

For office use only

Certificates Checked: _____ Signed: _____
 Insurance Checked: _____ Date: _____