REMEDIAL MASSAGE THERAPISTS ASSOCIATION

Office Use Only
Membership # ____**STUDENT**_____
Approval Date:_____
Change Date:_____
Rcpt#:_____

STUDENT MEMBERSHIP APPLICATION

Personal Information

First Name: _____ Last Name: _____ Initial: ____
Personal Email: _____
Date of Birth: (DD/MM/YYYY) _____ Gender: ❑ Male ❑ Female
Home Telephone: (_____)_____Cell: (_____)_____
Home Address: _____
City:_____ Prov:_____ Postal Code: _____

Education and Training

Commenced a minimum of a 1000 hour program
School Name: _____
Address: _____
Number of Hours:_____
Date of Graduation (DD/MM/YY): _____

Attach a confirmation of enrollment letter stating your proposed completion date for first year.

Type of Student Membership

My practical hours will be performed at: check one

❑Onsite student clinic (see Option 1)

❑Offsite private clinic (see Option 2)

❑Other_____

Option 1- association fee is complimentary
❑ I would like a membership that does NOT offer commercial general liability and professional liability insurance because my school's insurance policy covers me during my practicum.

Option 2- association fee is complimentary
❑ I would like a membership that DOES offer commercial general liability and professional liability insurance that covers me solely while I perform my practical hours. Please send me the insurance application form so I can apply and pay the necessary fees. (**Please note**: The annual cost of insurance is $95 and is paid directly to our broker. You will receive instructions with the insurance application.)

Personal Information Protection Act (PIPA)

Personal information is used only for internal database purposes. In the event that a member's residential address is also their business address, it is understood and agreed by the member, as signed below, that this information may be given out by the RMTA for business purposes only.

In order to provide and improve member services, the RMTA collects the personal and business related information contained within this application. Other than your name, city, province, membership status and the above mentioned business contact information, information you provide on this form is confidential and will only be used for the provision of member services and statistical reporting in accordance with the PIPA. The signature below is to be considered as consent to the collection, use and disclosure of personal information as described.

Signature: _____

I, the undersigned, declare that the information provided and statements made in this application and any attached documents are true. I understand that I will operate within the scope of practice as a Student reflecting my current level of training. I also agree that I am not able to write receipts for my services as I have not fully completed my training.

I further understand that if I do not submit my completed program documentation stating that I have obtained a minimum of 1000 hours of education within sixty (60) calendar days of completing first year, along with a completed application for Associate membership including fees, that my membership will be cancelled effective immediately.

Signature: _____ **Date:** _____

Requested Effective Date:_____
*If you would like your application effective as soon as possible, please put **ASAP.** Effective dates cannot be before the submission of your application.*

Application Checklist

- ❑ **Completed application form**
- ❑ **Criminal Record Check-** including vulnerable sector check *completed within the last 90 days*
- ❑ **Confirmation of enrollment letter**

Please Note: Incomplete applications will not be processed until all information is submitted. No refunds will be given for cancellation of membership for any reason.