

APPLICATION FORM

MR/MRS/MISS/MS	SURNAME	FORENAME	D.O.B.
ADDRESS			POSTCODE
TELEPHONE NO.	FAX	E MAIL	
THERAPIES		QUALIFICATION INITIALS	
COLLEGES/SCHOOLS		DATE QUALIFIED	
PRACTICE ADDRESS IF DIFFERENT FROM ABOVE		TELEPHONE NO.	
		PRACTICE YEARS	
PREVIOUS/CURRENT INSURING ASSOCIATION			

BEING THE SIGNATORY OF THIS APPLICATION, I AFFIRM THAT I AM IN GOOD PHYSICAL AND MENTAL HEALTH AND DO NOT HAVE A CRIMINAL RECORD OR HAVE BEEN EXCLUDED FROM ANY PROFESSIONAL REGISTER.

**SIGNATURE.....
DATE.....**

I CONFIRM THERE ARE NO PAST OR OUTSTANDING ACTIONS/CLAIMS AGAINST ME AND I HAVE NEVER HAD AN APPLICATION FOR INSURANCE DECLINED. I AFFIRM THAT ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

**SIGNATURE:.....
DATE:.....**

**YEARLY FEE ONE HUNDRED AND EIGHTY FIVE POUNDS (185.00)
CHEQUES MADE PAYABLE TO THE ASSOCIATION OF
OSTEOMYOLOGISTS OR PAY BY CREDIT CARD / PAYPAL VIA
WEBSITE**

PHOTOCOPIES OF QUALIFICATIONS, C.V.'s , AND CURRENT INSURANCE MUST BE SENT WITH APPLICATION FORM. OR REQUEST FOR INSURANCE APPLICATION FORM. SEND YOUR APPLICATION FORM TO - 80 GREENSTEAD AVE, WOODFORD GREEN ESSEX IG8 7ER