APPLICATION FOR MEMBERSHIP – NEW GRADUATE

Please complete this form and return to:
Membership Services Administrator, McTimoney Chiropractic Association,
Crowmarsh Gifford, Wallingford, Oxfordshire, OX10 8DJ.

Accompanying notes are provided to assist you.

TO BE COMPLETED BY THE APPLICANT:

A. About you

Title _____ Registered forenames _____

Registered surname _____

Former names _____

Forename and surname for use on MCA Membership Certificate _____

Home address _____

County _____ Postcode _____

Telephone _____ Mobile _____

Email _____

Date of birth _____

B. About your chiropractic training

Date qualified _____ Training establishment _____

Qualification obtained _____

Please indicate whether or not you intend to practise abroad _____

If YES, in which country? _____

C. About your other qualifications and training

Please give details of any other significant qualifications:

Date qualified _____ Training establishment _____

Qualification obtained _____

Date qualified _____ Training establishment _____

Qualification obtained _____

Have you ever applied to, or been a member of, any other professional body in the past? _____

If YES, please give details:

Name of association/organisation _____

Dates of membership_____ Level of membership _____

Name of association/organisation _____

Dates of membership_____ Level of membership _____

D. About your insurance

Give details of previous/existing professional indemnity insurance related to your training course or any other therapy practised.

Cover provided for (e.g. Therapy work/chiropractic training)

_____ _____

_____ _____

Type of cover_____

Dates of period of cover _____

Please give brief details of any resolved complaints made against you within the past 5 years.

_____

_____

Please give details of any unresolved complaints of which you are the subject, or in which you have been named or implicated.

_____

_____

E. About your practice Please note: * these fields are searchable on our website.

Your Main practice

Are you the Principal chiropractor here? YES NO

Address 1 _____

Address 2 _____

Address 3 _____

Town / District *_____City *_____

County *_____Postcode *_____

Telephone _____

Email _____

Website address _____

From this clinic do you plan to work... (Please circle the relevant option)

1. FROM HOME 2. FROM A CLINIC 3. OTHER_____

A. ON YOUR OWN B. WITH OTHER CHIROPRACTORS C. IN A MULTI-DISCIPLINARY CLINIC

Other practice

Are you the Principal chiropractor here? YES NO

Address 1 _____

Address 2 _____

Address 3 _____

Town / District *_____City *_____

County *_____Postcode *_____

Telephone _____

Email _____

Website address _____

From this clinic do you plan to work... (Please circle the relevant option)

1. FROM HOME 2. FROM A CLINIC 3. OTHER_____

A. ON YOUR OWN B. WITH OTHER CHIROPRACTORS C. IN A MULTI-DISCIPLINARY CLINIC

E. About your practice (Continued…)

Please indicate the techniques you practise **for which you are insured** with an approx percentage

Just to clarify what the percentages mean; 80% McT and 20% MAS means that you spend 20% of your **time** using massage and 80% of your **time** delivering McTimoney chiropractic.

Technique	**%**
Chiropractic Techniques	
Bio geometric Integration Concepts	
Bio Energetic Synchronization Technique (B.E.S.T.)	
Diversified	
Epley	
Koren Specific technique	
McTimoney	
Sacro-Occipital Technique	
Soft Tissue	
Chiropractic Techniques with instrumentation	
Activator	
Torque Release Technique/Integrator	

Technique (continued…)	**%**
Adjunctive Therapies	
Applied Kinesiology	
Bowen Therapy	
Craniosacral Therapy	
Dry Needling	
Exercises/Rehabilitation	
Massage	
Power Assisted Micro-Manipulation	
Remedial/Sports Massage	

Do you have any special interests for example… (Please circle the relevant interests)

A. PAEDIATRICS B. SPORTS CHIROPRACTIC C. GERIATRICS D. SOFT TISSUE WORK E. ANIMALS

OTHER _____

If Animal Chiropractic please give details of any training in animal chiropractic techniques

Date qualified _____Training establishment _____

Qualification obtained _____

F. Sponsorship

The Principal of the McTimoney Chiropractic College (or their nominated representative) will be asked by the MCA to sponsor your application to join the Association. If you have any objection to this, please contact the MCA Office straight away.

G. Declaration

Professional indemnity insurance is a requirement of registration.

☐ a) I intend to take advantage of the McTimoney Chiropractic Association bloc scheme with H & L Balen

☐ b) I intend to arrange my own professional indemnity insurance
(Please provide a copy of your professional indemnity insurance certificate)

I……., (name) understand that completion of Post Registration Training is a mandatory requirement of membership for the McTimoney Chiropractic Association and failure to complete the scheme will result in my membership being downgraded to Associate membership.

I also understand that the use of any diversified technique must be covered by an appropriate level of insurance, for which an additional premium may be payable. Responsibility for arranging this lies with me and failure to maintain appropriate cover may result in my insurance being invalidated.

Therefore having read and understood the Constitution and the Code of Ethics and Disciplinary Procedure of the McTimoney Chiropractic Association do apply for membership of the Association. I confirm that to the best of my knowledge the information given on this form is correct.

Signature _____Date _____

☐ **More information supplied on a separate sheet**

H. Data Protection Statement

The information provided on this form will be held on a database by the McTimoney Chiropractic Association, which is registered as a data user under the Data Protection Act. You are entitled by law to be told whether any personal data is held on you and to be supplied with a copy of all such information.

The Association is entitled to make a charge for supplying this information (maximum £10)

TO BE COMPLETED BY THE MCA OFFICE:

Qualification Certificate received YES/NO

General Chiropractic Council Registration number _____

Level of membership _____ Membership Number _____

Date approved by the Executive Committee _____

Insurance Cover _____

Please complete this form and return to:
Membership Services Administrator, McTimoney Chiropractic Association,
Crowmarsh Gifford, Wallingford, Oxfordshire, OX10 8DJ.