

Associate or Student Membership Application Form

Incorporated Association No. IA55484



IACN International Association of
Clinical Neuropsychotherapy

I, being the applicant named on this application for membership, desire to become a Member of the International Association of Clinical Neuropsychotherapy (IACN) Incorporated (an association incorporated in Queensland) and hereby agree, if admitted to membership, to be bound by the Rules of the IACN Incorporated for the time being in force and hereby authorise my name and contact details to be placed on the Register of Members.

Name: _____

Position/Role: _____

Employer/Self-employed: _____

Postal Address: _____

Post Code: _____

Email and Skype: _____

Phone: (home) _____

Phone: (work hours) _____

Mobile: _____

Main area of work (tick all that apply)	<input type="checkbox"/> Psychology <input type="checkbox"/> GP <input type="checkbox"/> Psychiatry <input type="checkbox"/> Counsellor <input type="checkbox"/> Social Work <input type="checkbox"/> Other Medical <input type="checkbox"/> Educational <input type="checkbox"/> Volunteer/support work <input type="checkbox"/> Other _____
Professional membership/s	Primary professional body membership: _____ Membership number: _____ Other: _____
Your qualifications	<input type="checkbox"/> PhD <input type="checkbox"/> Masters Degree <input type="checkbox"/> BSc/BA <input type="checkbox"/> Grad Dip. <input type="checkbox"/> Grad Cert. Year of qualification: _____ Other Qualifications: _____
Years in practice	<input type="checkbox"/> 1 – 5 <input type="checkbox"/> 6 – 10 <input type="checkbox"/> >10
How would you best describe your current role?	<input type="checkbox"/> Government employed <input type="checkbox"/> In private practice <input type="checkbox"/> Volunteer <input type="checkbox"/> Qualified but not currently practicing <input type="checkbox"/> Retired <input type="checkbox"/> Other _____

COMPLIMENTARY eJOURNAL ACCESS

I wish to receive the free Mediros eJournal
<http://www.mediros.com.au/resources/downloads/>

I wish to subscribe free to the International Journal of Neuropsychotherapy
<http://www.neuropsychotherapist.com/journal/>



MEMBERSHIP CATEGORIES* (with annual fees)

\$50 Associate Membership

\$25 Student Membership[†]

***Certified** and **Full** memberships are available at \$75 per annum after attendance at the 3.5 day Clinical Neuropsychotherapy Practitioner Training (see the Mediros website www.mediros.com.au for more details).

[†] Students currently enrolled and studying must provide details of current enrollment with this application. Students who are deferred must contact the Secretary to discuss membership options.

PAYMENT METHODS

Cheque (Please make cheque payable to IACN Inc.)

EFT DETAILS – IACN Inc. BSB 014 281 Acc # 4040 19322

You must record your name in the “message/reference” field of your internet banking website and attach a transfer receipt to this application. If you already know your transfer receipt number/reference, please write it here _____.

Credit Card (Mastercard or Visa only)

Card Number: _____ Expiry Date: _____

Three digits on back of card _____ Amount: _____

Name on Card: _____ Signature: _____

Receipt: Your receipt and membership details will be issued once the Management Committee has accepted your membership. Please note this may take up to 30 days.

APPLICANT: I acknowledge that I am a health professional (or a currently enrolled student[†]) who holds a recognised professional qualification and I accept the Rules of Membership which are available to me on request from IACN Inc.

[†] As a student you are not required to hold a current professional qualification.

Signature: _____

Date: _____

Please complete this form, sign, scan and email it to: (Secretary) at office@iacn.com.au

Alternatively please post it (with your cheque and attachments) to: IACN Secretary, PO Box 6460, St Lucia, QLD, 4067.

(ph: +61 7 3217 7266, fax: +61 7 3294 3220)

For IACN use: Admission date: _____ Proposer/seconded: _____

PRIVACY DISCLAIMER: The collection of your name and email address is so that we may register you as a member of the IACN. This information will be stored by the IACN in a database and may be used for future marketing and information purposes as well as a publicly accessible website search function, but will not be disclosed to a third party without your permission. If you do not wish your details to be used in this way, please check this box . If this box is left unchecked then the IACN will consider that the individual/s completing this form give consent to their name and email address being used in the manner indicated.

International Association of Clinical Neuropsychotherapy
PO Box 6460
St Lucia QLD 4067

Contact: IACN Secretary
Email: office@iacn.com.au
Website: www.iacn.com.au