



MEMBERSHIP APPLICATION

Ten steps towards joining the CMA

IMPORTANT

This witnessed application form along with certified graduation certificate and certified academic transcript must be posted and received as hard copies. All other items can be emailed and do not require certification.

1. PERSONAL DETAILS

Title: Mr Mrs Miss Ms Other Date of Birth..... Mobile.....

(a).....
Surname Given Names

(b) Home Address
State Post Code Ph.....

(c) Business Address
State Post Code Ph.....

(d) Postal Address

(e) Email/s.....

Passport Photo

If you do not have a passport photo, a digital head shot may be taken and attached or emailed

2. PRACTICE TITLE(S)

As a member of the Complementary Medicine Association, you will be recognised as, and expected to use the title/s: *Naturopath, Homeopath, Nutritionist, Western Herbal Medicine, Chinese Herbal Medicine, or Ayurveda Practitioner.*

Please indicate the titles you practice under:

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Naturopath | <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Homeopath |
| <input type="checkbox"/> Western Herbal Medicine Practitioner | <input type="checkbox"/> Ayurveda Practitioner | |
| <input type="checkbox"/> Chinese Herbal Medicine Practitioner | <input type="checkbox"/> Other (please specify) | |

3. PHOTOGRAPHS OF PRACTICE PREMISES AND FACILITIES

If you are practising, clinic photographs must be emailed to the administration office. They are required for all practice locations, including home based clinics. If operating online, please supply one of the outside of the premises and dedicated space where consultations will be undertaken. Where applicable, photographs must clearly show the following:

- The front elevation of the premises showing (where possible) the street number. This photo, or additional photos should also include any advertising material or signs on display to the public.
- The waiting room/s.
- The consulting room/s.

This is designed to assist the Federal Executive in ensuring that all Members provide a clean and presentable practice environment. All locations must be of a professional standard. No clinic will be added to a file without photographic evidence.

The Federal Executive reserves the right to inspect the practice premises of association members at any time.

4. ACADEMIC BACKGROUND & PROFESSIONAL EDUCATION

(a) Tertiary / other relevant education

.....

(b) University / College attended

.....

Certified copies of certificates & academic transcripts must be included with this application

(c) Further natural therapies courses under current study, number of units completed & expected completion date

.....

(d) How were studies undertaken? On campus Online Mixed # Hours online

(e) Were clinical practicum / practical hours completed? Yes No # Hours completed.....

(f) Where were practical hours undertaken? On campus External Other

5. PROFESSIONAL PRACTICE INFORMATION

(a) Not practising Full Time Part Time Approximate hours of practice per week

(b) How long have you been in continuous practise? Approximate date when first commenced

(c) Is the practice your primary source of income Yes No

If no – please indicate your primary source of income

.....

MODALITIES UTILISED IN CURRENT PRACTICE

Nutritional Therapy Naturopathy Herbalism Homoeopathy

Ayurveda Chinese Medicine Other (please specify)

.....

(e) DIAGNOSTIC METHODS USED

Symptomatology Blood Differential Eye

Physiognomy Urine Saliva Other please specify)

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6. INSURANCE, FIRST AID, WORKING WITH CHILDREN CHECK

If you are practising, you must hold current insurance, first aid and a paid/employee *working with children (wwc) check. If these items are not held at the time of application, they can be forwarded after approval.

(a) Name of Insurer Expiry Date

Level of professional indemnity cover \$ Level of public/products liability cover \$

Professional indemnity must be a minimum of \$2M and public/products liability \$10M.

(b) Do you hold current first aid? Yes No Expiry date

(c) Do you hold a WWC check Yes No Card #..... Expiry date

* wwc, working with vulnerable people and blue cards are only required if you meet the criteria under your states legislation.

7. OTHER PROFESSIONAL MEMBERSHIPS

- (a) Do you hold current membership with another association/professional body? Yes No
If yes, which one? level of membership for how long?
- (b) Have you previously held membership with another association/professional body? Yes No
If yes, which one? level of membership for how long?
Reason for leaving?
- (c) Have you ever been refused entry to a natural therapy association/professional body? Yes No
- (d) Have you ever been disciplined **or** expelled from a natural therapy association/professional body? Yes No
- (e) Have you ever been investigated by any health fund? Yes No
- (f) Have you ever been convicted of a criminal offence **or** faced disciplinary proceedings? Yes No
- (g) Do you have any pending complaints against you? Yes No

If yes to c, d, e, f, or g, please attach all relevant information pertaining to the reason/s and outcome of disciplinary action, investigation, charges, or complaint.

8. MEMBERSHIP CATEGORIES & ENTRY STANDARDS

Application for membership of the Association will be received by the Federal Executive and accepted conditional to the applicant adhering to the Constitution, Code of Ethics and fulfilling the following criteria.

- (a) Being that he/she is 18 years of age or above or, in the case of student members 16 years or above.
- (b) That he/she is considered by the Federal Executive to be a fit and proper person to be a member of the Association.
- (c) Meet the requirements of at least one of the following membership categories.

FULL MEMBERSHIP:

May be granted to the applicant providing that he/she has:

A **minimum** of an Advanced Diploma in: Naturopathy, Nutrition, Homeopathy, Western Herbal, Chinese Herbal or Ayurveda from an Australian Recognised Training Organisation (RTO) or University. Please note that Chinese Herbal Practitioners must hold a relevant equivalent qualification and be registered with AHPRA.

A considered equivalence in both RTO and/or non-RTO education and experience per CMA Policy – Notice of Change in Entry Requirements – Enacted 14th October 2007.

PROVISIONAL MEMBERSHIP:

May be awarded to practising Naturopaths, Nutritionists, Homeopaths, Western Herbal, Chinese Herbal or Ayurveda Practitioners, who fall short of our current minimum entry requirement, but are currently undergoing study to upgrade their qualifications. It allows them to continue to practice whilst doing so.

As per CMA Policy – Notice of Change in Entry Requirements – Enacted 14th October 2007. Provisional membership is valid for a maximum of three years from the date the membership is granted.

STUDENT MEMBERSHIP:

May be granted providing he/she is undertaking a recognised course of training in Naturopathy, Nutrition, Homeopathy, Western Herbal or Chinese Herbal Medicine or Ayurveda at an Australian Recognised Training Organisation (RTO) or University.

ASSOCIATE MEMBERSHIP:

May be granted providing he/she holds a supportive interest in the Association's Aims and Objectives, is over 18 years of age and who meets the requirements of step 8 (b).

Associate membership may also be granted to an applicant who wishes to hold CMA membership (with no provider status) whilst retaining another association's membership, which provides Health Fund benefits.

Entry standards for the CMA are regularly reviewed to reflect the growing requirements being developed within the profession.

The Executive stress that the above entry criteria can change at any time without notice and is provided as a guide only to applicants to assess their eligibility. The final decision rests with the Federal Executive of the Association who reserve the right to treat each application individually, without being restricted or bound by these guidelines.

9. APPLICATION AND MEMBERSHIP FEES

- Annual memberships run from April 1st to March 31st.
- If joining part way through a membership year, pro-rated fees are payable as per the below.
- An invoice for the application fee will be issued upon receipt of application form.
- Application and membership fees once paid, are non-refundable.
- All Fees outlined below are subject to the addition of gst.

Membership Level	Total Annual Fee	Pro-rated if joining July – September	Pro-rated if joining October - December	Pro-rated if joining January - March
Full	\$340.00	\$255.00	\$170.00	\$85.00
Full *Non-Practising	\$170.00	\$127.50	\$85.00	\$42.50
Provisional	\$200.00	\$150.00	\$100.00	\$50.00
Associate	\$100.00	\$75.00	\$50.00	\$25.00
Application Fee	Full & Provisional - \$50.00		Associate - \$25.00	

* non-practising membership is only available to existing full Members

10. DECLARATION:

I SOLEMNLY AND SINCERELY DECLARE THAT:

- I am the person named and shown in the documents accompanying this application, (which consists of 4 pages).*
- Documentary evidence of my educational and professional qualifications submitted with this application remain current at the date hereof and no action is pending in respect thereto.*
- I agree to be bound and abide by the rules and regulations established by the Federal Executive of the Complementary Medicine Association Ltd. Including, but not limited to its Constitution, Code of Ethics and By Laws.*
- I acknowledge that the Federal Executive of the Complementary Medicine Association Ltd may in its absolute discretion grant or refuse membership of any or all disciplines applied for, or withhold, suspend, or withdraw membership in general or in respect of any disciplines without assigning any reason, therefore.*
- I confirm that this application is submitted with full knowledge and consent that in the event of membership being refused the application fee is not refundable. I further confirm with full knowledge and consent, that should a membership be granted, all monies paid are not refundable.*

I MAKE THIS SOLEMN DECLARATION, CONSCIOUSLY BELIEVING SAME TO BE TRUE AND BY VIRTUE OF THE PROVISIONS OF THE "OATHS ACT OF 1900 – 1935". SUBSCRIBED AND DECLARED AT

Signed by This day of 20.....
(Applicant's signature)

Before me Name
(JP or Authorised person's signature) (JP or Authorised person's name)

Location Phone

**MAIL THIS ORIGINAL APPLICATION AND CERTIFIED QUALIFICATION DOCUMENTATION TO:
CMA Federal Administration, P.O. Box 1109, OXFENFORD QLD 4210**

admin@cma.asn.au | www.cma.asn.au | 07 5580 5990

How did you find out about the CMA? Current student Education provider Other
 Colleague/Existing CMA Member (please provide members name)