



# REMEDIAL MASSAGE THERAPISTS ASSOCIATION

Office Use Only

Membership # \_\_\_\_\_

Approval Date: \_\_\_\_\_

Change Date: \_\_\_\_\_

Rcpt#: \_\_\_\_\_

## ASSOCIATE MEMBERSHIP APPLICATION

### Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Date of Birth: (MM/DD/YY) \_\_\_\_\_ Gender:  Male  Female

Personal Email: \_\_\_\_\_

### Education and Training-

Minimum 1000 hours of training

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Graduation (DD/MM/YY): \_\_\_\_\_ Number of Hours \_\_\_\_\_

Document awarded (please attach a copy):

Certificate  Diploma  Other (please indicate): \_\_\_\_\_

Confirmed Enrollment in a minimum 1200 hour program- Attach a Confirmation of Enrollment letter

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Projected Date of Graduation (DD/MM/YY): \_\_\_\_\_ Number of Hours \_\_\_\_\_

\*Completed program documentation must be submitted within sixty (60) calendar days of graduation date.\*

\*\* Do you have any criminal convictions?  Yes  No

If yes, please include a copy of a current criminal records check and provide the specifics of your conviction including the Court and date of any actions. The Association reserves the right to refuse membership based on related or relevant criminal convictions.

The following information will be posted on the website under "Find a Therapist"

### Professional Information

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

City/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Business Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Business Email: \_\_\_\_\_



## Clinical Practice Setting

Please indicate in what types of setting you currently provide treatment services. Check **all** that apply.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Private Practice in a Clinic | <input type="checkbox"/> Private Practice in Home           | <input type="checkbox"/> Sports Clinic / Facility |
| <input type="checkbox"/> Chiropractor Clinic / Office | <input type="checkbox"/> Fitness Centre, Spa or Health Club | <input type="checkbox"/> Hospital                 |
| <input type="checkbox"/> Mobile /On-Site              | <input type="checkbox"/> Resort or Hotel                    |   |
| <input type="checkbox"/> Other: _____                 |   |   |

## Treatment Types

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Therapeutic Massage                  | <input type="checkbox"/> Relaxation Massage | <input type="checkbox"/> Pregnancy Massage      |
| <input type="checkbox"/> Infant Massage                       | <input type="checkbox"/> Trager             | <input type="checkbox"/> CranioSacral Therapy   |
| <input type="checkbox"/> Acupressure                          | <input type="checkbox"/> Hot Stone Massage  | <input type="checkbox"/> Reflexology            |
| <input type="checkbox"/> Trigger Point                        | <input type="checkbox"/> Sports Massage     | <input type="checkbox"/> MVA / Rehabilitation   |
| <input type="checkbox"/> Myofascial Release                   | <input type="checkbox"/> Lymphatic Drainage | <input type="checkbox"/> Chronic Pain           |
| <input type="checkbox"/> Onsen                                | <input type="checkbox"/> Lensen™ Technique  | <input type="checkbox"/> BioFlex® Laser Therapy |
| Other: ( <input type="checkbox"/> direct billing, etc.) _____ |   |   |

(use a separate sheet if necessary)

## 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. The signature below is also considered as consent for the Registered Massage Therapists Association to publish business contact information and treatment types available in various formats as required from time to time, including the Find a Therapist area of the RMTA website.

**Signature:** \_\_\_\_\_

I, the undersigned, declare that the information provided and statements made in this application and any attached documents are true. I further understand that if I do not submit my completed program documentation stating that I have obtained a minimum of 2200 hours of education within sixty (60) calendar days of completion along with a completed application for full membership, including a valid certificate in First Aid and CPR, that my membership will be cancelled effective immediately.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Application Checklist

- Completed Form Page 1 and 2
- Copy of Education Credentials
- Copy of Confirmation of Enrollment letter
- Indicate Payment Method:
  - Cheque (enclosed with application)
  - Money Order (enclosed with application)
  - Credit Card (you will be contacted by the RMTA office for the card number)

**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.

