



REMEDIAL MASSAGE THERAPISTS ASSOCIATION

Office Use Only

Membership # _____

Approval Date: _____

Change Date: _____

Rcpt: _____

FULL MEMBERSHIP APPLICATION

Personal Information

Last Name: _____ First Name: _____ Initial: _____

Home Address: _____

City/Province: _____ Postal Code: _____

Home Telephone: (____) _____ Cell: (____) _____

Date of Birth: (DD/MM/YYYY) _____ Gender: Male Female

Personal Email: _____

Education and Training- We require documented proof of completion of 2200 hours of education from a recognized school of massage.

1. School Name: _____

Address: _____

Date of Graduation (DD/MM/YYYY): _____ Number of Hours _____

Document awarded (please attach a copy):

Certificate Diploma Other (please indicate): _____

2. School Name: _____

Address: _____

Date of Graduation (DD/MM/YYYY): _____ Number of Hours _____

Document awarded (please attach a copy):

Certificate Diploma Other (please indicate): _____

First Aid/ CPR for Infants and Adults

- attach a copy of your current First Aid/ CPR certificate

First Aid/ CPR Expiration 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: (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.

Signature: _____ **Date:** _____

Application Checklist

- Completed Form Page 1 and 2
- Copy of Education Credentials
- Copy of current First Aid/CPR certificate
- Indicate Payment Method:
 - Cheque (enclosed with application)
 - Money Order (enclosed with application)
 - Credit Card (you will be contacted via email with further instructions for payment)

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.