INSTITUTE OF CLINICAL HYPNOTHERAPY & PSYCHOTHERAPY

Graduates Association (ICHP-GA)

ASSOCIATE MEMBERSHIP

1 March 2018 – 28 Feb 2019

Title	Mr Mrs Miss Ms Dr Other: **(please circle)**		
First Name:		Surname:	
Home Address		Email:	
Home Phone:		Mobile Phone:	
Date of Birth:		Status:	Student – Retired – Interested party *Please circle one of the above*
Year	Qualifications		Institute
Paid by:	**Bank Transfer: €50 new/renewal** ICHP GA. IBAN: IE37 AIBK 9335 6231 6640 08 (BIC: AIBKIE2D) or **Paypal/Cheque: €55 new/renewal**		

Declaration:

1. **I declare** that all the information given including supporting documentation is true and accurate.
2. **I have read** the ICHP-GA Code of Ethics and Standards, Child Protection policy and undertake to abide by them and operate within them at all times, where relevant.
3. **I confirm** that I have never been convicted of a criminal offence and I have never been the subject of disciplinary proceedings by any professional body.
4. **I consent** to my name and contact details appearing on the ICHP GA website as an Associate Member.
5. **I enclose** a signed copy of my Supervision Form for last year countersigned by my Supervisor, together with a copy of my current Insurance Certificate (and copy of qualifications for new members).
6. **I confirm that I am not a practicing Hypnotherapist because I am a Student, Retired member of the Association or an interested party.**
7. **I consent** to the ICHP GA contacting me by phone and email. (If **not** tick this box: □)

_____ _____

Signature: _____ Date: _____ 2018

Please send Application form with enclosures to: Ms. Elizabeth Giles, Secretary ICHP-GA, Carrickmacross Wellness Centre, Glenview, Dunogue, Carrickmacross, Co. Monaghan.

Mobile: 086 1984179 - lizjgiles@icloud.com