

NEW MEMBER APPLICATION

Full Name: _____

Postal Address: _____

City/State/Postcode: _____

Personal Phone: _____ Mobile _____

Personal Email: please print _____

Place of Birth _____

Nationality _____

Where are you registered to Practice?

State/s _____ Reg'n No. _____

Other Country _____ Reg'n No. _____

Chiropractic & Other Educational Background

List your Academic Qualifications

Name of College or Institution	City, State & Country of Institution	Admission Date	Graduation Date	Degree or Diploma Awarded

For ALL New Applicants Before your application for membership can be approved by the Board of Directors, you need to have a current financial member of SOTO Australasia sponsor your application

Name & Address of a **current** SOTO Australasia member who will sponsor your application.

Full Name: _____

Postal Address: _____

City/State/Postcode: _____

Your SOT History

Seminar	No of Attendances	Year of Most Recent Attendance	Country of Attendance
Introduction & Categories (I, II, III)			
C.M.R.T.			
Cranial			
Advanced Modules (<i>name module</i>)			

☐ Phone: (07) 55 762 132 ☐ Email: hello@soto.org.au ☐ www.soto.org.au

S.O.T An Integral Part of EVERY Chiropractic Practice!

Your Practice Details

Clinic Name:	Clinic Name:
Address:	Address
State: Post code:	State: Post code:
Clinic Ph:	Clinic Ph:
Email:	Email:
Website:	Website:

How often do you use SOT?

Categories (I, II, III)	<i>Regularly</i>	<i>Sometimes</i>	<i>Rarely</i>
C.M.R.T.	<i>Regularly</i>	<i>Sometimes</i>	<i>Rarely</i>
Cranial	<i>Regularly</i>	<i>Sometimes</i>	<i>Rarely</i>

Do you have SOT Certification? Yes/No *Basic* *Advanced* *SOT Certified Craniopath*
If 'Yes' please tick what level?

How many years have you been using SOT? _____ Years

Please Tick	Membership Options	Calendar Year
	Full - Australian & New Zealand registered practicing chiropractors.	230.00
	Academic - Applies to retired, non-practicing chiropractors or practice hours under 10 hours a week.	115.00
	Associate - Applies to non-practicing chiropractic professionals working in conjunction with a SOT chiropractor.	115.00
	1st Year Grad - Applies in 1st year of registering as a chiropractor.	150.00
	Overseas - Applies to chiropractors practicing outside of AU.	75.00
	Please tick if you would like a membership certificate sent out	\$
	Amount Payable -	

Payment Details.

Credit Card (Mastercard only)

Card # Expiry

Cardholder name - _____

Bank Transfer - * Please forward renewal form, and invoice with bank details will be forwarded for payment

I, hereby apply for SOTO A Membership as above. Sign/Initial: _____ Date: _____

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