

## NEW MEMBERSHIP APPLICATION

### Member Contact Details

Full Name: \_\_\_\_\_

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

City/State/Postcode: \_\_\_\_\_

Personal Phone: \_\_\_\_\_ Mobile \_\_\_\_\_ Other \_\_\_\_\_

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 please visit <http://www.soto.net.au/Find-a-Practitioner> or call SOTO Office (07) 55 762 132) for further information required.

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

Full Name: \_\_\_\_\_

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

City/State/Postcode: \_\_\_\_\_

### Do you wish to be included on the SOTO Australasia website practitioner listing?

Yes  Please ensure you complete **Your Practice Details** page 2

No

### 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> )			

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### Your Practice Details

**Practice 1 or Locum**

Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Suburb \_\_\_\_\_ Code \_\_\_\_\_

Clinic Phone \_\_\_\_\_

Clinic Email (please print) \_\_\_\_\_  
 @ \_\_\_\_\_

**Practice 2**

Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Suburb \_\_\_\_\_ Code \_\_\_\_\_

Clinic Phone \_\_\_\_\_

Clinic Email (please print) \_\_\_\_\_  
 @ \_\_\_\_\_

### 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?

Do you have Diplomate Status?      Yes/No

How many years have you been using SOT?      \_\_\_\_\_ Years

### Subscription

**Membership Options**

	12 Months	-	Your Payment
<b>Full Membership</b> <i>(Applies to Australian &amp; New Zealand registered practicing chiropractors)</i>	<b>230</b>	-	
<b>Associate Membership</b> <i>(Applies to other non-chiropractic professionals working in conjunction with SOT practitioners)</i>	<b>115</b>	-	
<b>Academic Membership</b> <i>(Applies to chiropractic students, retired and non-practicing chiropractors)</i>	<b>115</b>	-	
<b>Grad Membership</b> <i>(Applies to 1<sup>st</sup> year Graduates)</i>	<b>150</b>	-	
<b>Overseas Membership</b> <i>(Applies to chiropractors practicing overseas)</i>	<b>75</b>	-	

### Payment Details Applications processed on receipt of payment.

<i>Credit Card</i>	<input type="checkbox"/>	Cardholder Name	Expiry date	
		Card Number		
<i>Bank Transfer</i>	<input type="checkbox"/>	Deposit to <b>BSB 064 424 Account Number 1051 1477 – Ref: your 'LAST NAME Membership'</b>		
<i>Cheque</i>	<input type="checkbox"/>	Cheques payable to <b>'SOTO Australasia'</b>		

**I hereby apply for Membership as indicated above**

*Signature* \_\_\_\_\_ *Application Date* \_\_\_\_\_