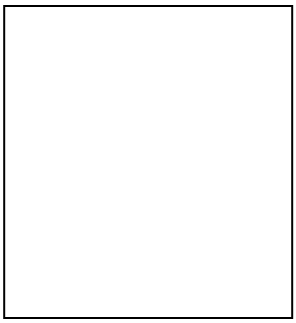
Association of Holistic Healthcare Practitioners of Ontario

New Membership Application Form

www.ahhcpo.com



Personal Data

Last Name: _____ First Name_____

Date of Birth_____ Place of Birth: _____

Home Address _____

Clinic Name and Address: _____

_____ _____

Home Phone:_____ Clinic Phone: _____

Cell Phone:_____ Fax:_____

Email:_____ Website:_____

Education

Degree	**University/College/Institute**	**Country**	**Year obtained**

Clinical Experience

Position/Title	Clinic/Institute	Year
Further Comments		

General Declaration

I hereby certify that all statements I have made on this membership form are true and complete to the best of my knowledge and belief. I understand that a false or misleading statement may disqualify me from registration or may be cause for revocation of any membership which may be granted to me.

Applicant signature: _____ Date: _____

Reference Name: _____ Reference Signature: _____

Documentation

Please enclose the following document with your application:

Two passport size pictures
Copy of diplomas obtained
Membership Fee
- $500 fee for the first time applicant
- $200 fee for each year renewal
- Payment can be made by Visa, MasterCard, Debit, Money order, Cash or Cheque

Mailing Address: The Association of Holistic Healthcare Practitioners of Ontario
13085 Yonge Street, Suite 205
Richmond Hill, Ontario
Canada L4E 3S8

Telephone: 289 234 9141 Fax: 289 234 5889

For Office Use Only:
Membership Number:

Date Issued: