Application for membership (Foot Health Practitioners)

Please complete this application form and send it along with two written references to:
The College of Foot Health, 150 Lord Street, Southport, PR9 0NP

PLEASE COMPLETE THIS FORM IN BLOCK LETTERS

Personal information:

Title: Mr / Mrs / Ms / Miss (**delete not applicable)*

Surname: _____

Forename(s): _____

Date of Birth: ____ /____ /_____

Address: _____

_____

Post Code: _____

Tel. *(Inc. Area Code)*: _____ Mobile: _____

Email: _____

Professional qualifications:

Qualifications currently held: _____

_____

What length of practical training did you receive? _____

Where did you receive your training? _____
(please enclose copies of your training / CPD certificates where applicable)

How long have you been practising? _____

APPLICATION FOR MEMBERSHIP

The College of Foot Health

Practice details:

Particulars of practice: *Surgery only / Surgery & Domiciliary / Domiciliary only (**delete not applicable)*

Practice / Employer's name: _____

Practice address: _____

_____

_____Post Code: _____

Telephone *(Inc. Area Code)*: _____

Insurance & Ethics:

Do you currently hold Professional Indemnity insurance cover? Yes ☐ No ☐

Whilst in practice, have you had any insurance claims made against you? Yes ☐ No ☐

If you've answered 'yes' to the above, do you have any insurance claims pending? Yes ☐ No ☐

Have you ever been refused insurance cover to practise foot health care? Yes ☐ No ☐

Have you ever been disciplined or declined membership of any other organisation? Yes ☐ No ☐
(If you've answered 'yes' you will be asked for further information)

If required to do so would you be prepared to sit a prescribed test of competence? Yes ☐ No ☐

Do you belong to any other professional body? Yes ☐ No ☐

If you've answered 'yes' to the above, please give details below:

_____

_____

_____

_____

_____

Fees:

Fees are only payable after your membership application has been accepted.

Annual Subscription: £250.00 [2020] ***plus*** £25.00 compulsory administration fee

Optional Insurance:

Option 1 Basic insurance as per summary of cover: £135.79 [2020]

- Details of the Insurance are contained in the Summary of Cover, a copy of which is available by contacting The College of Foot Health, 150 Lord Street, Southport, PR9 0NP.
- Members not joining the College's Insurance Scheme, are required to furnish proof of insurance.
- Fees are payable on acceptance and thereafter on 1st January each year.
- You must advise us of any material facts that may affect your cover - if you are in any doubt about whether facts are material, you must inform us - failure to do so could affect the validity of your policy.

APPLICATION FOR MEMBERSHIP

The College of Foot Health

Declaration:

Having duly read and understood the qualification for membership and the Ethical Rules and completed the attached Schedule, I wish to apply for admission as a Member of the College of Foot Health.

I hereby undertake not to engage in advertising outside of the regulations currently permitted by the Board of Ethics *(details of which are contained in the Bye-Laws)*.

Should my application be accepted, I do solemnly declare that, as a Member of the College of Foot Health, I will observe the conditions of the Memorandum & Articles of Association and Bye-Laws, Ethical and other Rules and Regulations thereof; and I will conduct myself honourably in the practice of the profession and maintain the dignity and welfare of the College.

I certify that I do not suffer from any physical or mental condition that could adversely affect me from safely and competently practising foot health. I declare that to my knowledge, I do not suffer from any condition or illness that may be contracted by, or be a danger to, a third party.

I warrant that my answers to the attached questions form the basis of my application for Membership and that any error shall entitle the Association to refuse to admit me or to cancel my membership if any error shall be ascertained subsequently to my having been admitted to membership.

Applicant's signature: _____ Dated: _____/_____/_____

Witnessed by (name): _____

Occupation: _____

Address: _____

_____

Signed: _____ Dated: _____/_____/_____

The College of Foot Health

Referee Statement

Please return the completed form to: The College of Foot Health, 150 Lord Street, Southport, PR9 0NP

PLEASE COMPLETE IN BLOCK LETTERS

Applicant's details:

Surname: _____

Forename(s): _____

Address: _____

_____

_____ Post Code: _____

Referee's details:

Name: _____

Address: _____

_____

_____ Post Code: _____

Occupation: _____

Name & address of employer: _____

_____

_____ Post Code: _____

Official Company stamp ***(if applicable):***

Referee's statement:

Please use the space below to comment on the applicant's suitability in to the Institute of Chiropodists and Podiatrists, stating how long you have known the applicant and in what capacity.

Referee's signature: _____ Dated: _____/_____/_____

The College of Foot Health

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_____ Post Code: _____

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