



# College of Chiropractors

## Membership Application Form

PLEASE COMPLETE ALL SECTIONS AND THE DECLARATION. YOUR APPLICATION WILL BE PHOTOCOPIED.  
PLEASE USE **BLACK INK** AND WRITE IN CAPITALS OR TYPE

<b>SECTION 1</b>				
<b>PERSONAL INFORMATION</b>				
Title	Family name	First forename	Initials	Post-nominal letters
Correspondence address:		Main practice address:		Please affix a passport-sized photo here:
Postcode :		Postcode :		
Telephone :		Telephone :		
Fax :		Fax :		
Date of birth:		Mobile no:		
Email address:				

<b>SECTION 2</b>			
<b>EDUCATION</b>			
<b><i>Primary chiropractic qualification</i></b>			
Date	Qualification awarded	Chiropractic institution	For office use only
<b><i>Other chiropractic qualifications</i></b>			
Date	Qualification awarded	Awarding body	For office use only
<b><i>Other qualifications (degree, post-graduate, other professional only)</i></b>			
Date	Qualification awarded	Awarding body	For office use only
Number of years/month in practice as a chiropractor:		years	months



**SECTION 5a**  
**UK GENERAL CHIROPRACTIC COUNCIL (GCC) REGISTRATION**

Are you registered as a chiropractor with the UK GCC? Please tick box:	Yes <input type="checkbox"/> No <input type="checkbox"/>	For office use only
If yes, please give details. If no, please complete Section 5b below.	Reg. no. <input type="text"/> Effective date <input type="text"/> Category <input type="text"/>	

**SECTION 5b**  
**REGISTRATION WITH REGULATORY BODY IN COUNTRY OF PRACTICE IF NOT UK**

Please provide the name and contact details for the Chiropractic Regulatory Body in your country of practice.	Name of Regulatory Body: <input style="width: 90%;" type="text"/> <hr/> Address of Regulatory Body: <input style="width: 90%;" type="text"/>  Telephone: <input style="width: 90%;" type="text"/>	For office use only
Are you registered as a chiropractor with this body? Please tick box:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please give details:	Reg. no. <input type="text"/> Effective date <input type="text"/> Category <input type="text"/>	

**SECTION 6**  
**MALPRACTICE**

Please state whether there are any facts or matters currently known to you in respect of past acts or omissions which are or might be the subject of any criminal investigation or whether there are any outstanding complaints against you from patients or others to whom you have provided care or by or from former employers which relate to your conduct. Please append details.

<b>SECTION 7</b>			
<b>PROPOSER / SECONDER (both must be existing Fellows or Ordinary Members of the College)</b>			
<b>PROPOSER</b>		<b>SECONDER</b>	
Name: (please print)		Name: (please print)	
Address:		Address:	
Length of time you have known this applicant:		Length of time you have known this applicant:	
Proposer's signature:		Secunder's signature:	

<b>SECTION 8</b>			
<b>DECLARATION</b>			
<b>I declare that the information provided above is a true record.</b>			
<b>Signed</b>		<b>Date</b>	

**Please return your completed form to:**

College of Chiropractors  
 Chiltern Chambers  
 St. Peters Avenue  
 Reading RG4 7DH  
 United Kingdom

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