2017 MEMBERSHIP REINSTATEMENT APPLICATION

Massage Therapy Association of Manitoba

Massage Therapy
ASSOCIATION OF MANITOBA INC.

NOTE: *If you have not been practicing massage therapy in Manitoba or another jurisdiction for five years, you may not be not eligible to re-join the MTAM. Please contact us to discuss your case.*

PLEASE PRINT:

Name: _____

Address: _____

City/Town: _____

Postal Code: _____

Telephone: _____ **Cell Phone:** _____

Email: _____

REINSTATEMENT AGREEMENT:

I hereby make application for reinstatement of membership in the Massage Therapy Association of Manitoba, Inc. (i.e., MTAM). I am enclosing a non-refundable reinstatement application fee of $100.00 plus GST ($105.00) for this purpose. Payment by certified cheque, money order, EFT (electronic funds transfer), Visa/MasterCard.

I understand that reinstatement of membership is at the sole discretion of the Board of Directors, and may be approved with or without conditions, or declined entirely. If accepted for reinstatement I will be required to pay the appropriate membership fees of the MTAM based on its regular pro-rated membership scale and abide by its bylaws & policies as established.

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Signature   *Date*

PLEASE SELECT A PAYMENT METHOD:

☐ Cheque (payable to MTAM) ☐ Cash ☐ e-Transfer ☐ Visa ☐ MasterCard

Card No: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiry:_____/_____ CSV: _____

Cardholder Name (as it appears on the card):

Address of Cardholder (if different than given above):

WE ARE HERE TO SERVE YOU

If you have any questions regarding your application or require assistance, we are here for you.

Call us anytime!
204-927-7979

Return your completed application by mail to:

304-428 Portage Ave.
Winnipeg, Manitoba
R3C 0E2

Or call or email us
info@mtam.mb.ca

to set an appointment to drop off your application in person.

Thank you!

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DOCUMENT CHECKLIST:

This application <u>must include</u> the following documents to be considered complete:

☐ **Continuing Education History**. Provide a list of any continuing education courses/workshops relevant to massage therapy that you have completed in the past four (4) years. Copies of certificates, transcripts, or letters confirming completion of each of these must be included with the list. Reinstated members will be required to complete the necessary education in lieu of the previous four years away from the MTAM.

☐ **Current CPR-Level C** or CPR-HCP Certificate (online courses are not acceptable); photocopy acceptable.

☐ **Criminal Record Check with Vulnerable Sector Search** – please provide the <u>original signed report</u> from the Winnipeg Police Service or Police Service responsible for your jurisdiction, completed no more than *six months prior to the date of application.*

☐ **Practicing Member Agreement** (included in this application document) – signed and witnessed

☐ **A letter that explains why you want to reinstate** your MTAM membership. Also include information about where you plan to practice, if known.

☐ **Summary of clinical hours** where you have practiced as a massage therapist since your MTAM membership was cancelled – in Manitoba or any other jurisdiction (if applicable).

☐**Letter or certificate of good standing** from the massage therapy professional association or regulatory college of which you are/were a member (if applicable)

☐ **Documentation of any official change of name** since terminating your MTAM membership, if applicable.

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PRACTICING MEMBER AGREEMENT

The undersigned applicant for Practicing Membership hereby agrees to abide and be bound by the Massage Therapy Association of Manitoba Inc.'s (MTAM) By-laws, Code of Ethics, Conflict of Interest Code, Policies, Standards of Practice, together with all amendments thereto from time to time, and all additional by-laws, codes, guidelines, policies, practices, procedures and standards that may be implemented by the MTAM from time to time.

*I hereby make application for a **Practicing Membership** with the Massage Therapy Association of Manitoba Inc. (MTAM) and for Professional Liability and General Liability insurance as provided by the Association for the period from date of this application through **December 31, 2017.***

I understand that the insurance coverage provided by the insurer is subject to all terms, conditions and exclusions contained in the Master Policy. Failure to pay required premiums, and/or false statements for this application or subsequent renewals shall void this application and render my insurance coverage null and void.

I understand that if I am in violation of the MTAM By-laws, MTAM Code of Ethics, or any MTAM Policies and Procedures established by the Board of Directors, including my compliance with the MTAM Education & Continuing Competency Program that my membership privileges may be terminated. I further understand that if my membership is terminated for any reason, that the MTAM has the right to contact my applicable workplaces and / or associated clinics to inform them of the termination.

*I confirm I have the legal right to work in Manitoba (e.g., Canadian citizenship, landed immigrant status, work permit/visa) and **have disclosed to the MTAM the details of any prior or new criminal conviction in Canada or elsewhere, and any new or outstanding criminal charges**.*

I consent to the collection, use, and referral/disclosure of business contact information in accordance with the MTAM Privacy Policy. I also understand that by signing this form, I am consenting to receive communications and information from the MTAM by email, mail, fax and/or telephone to the contact information in my profile and respond to correspondence related to my professional obligations as a member promptly.

Furthermore, I agree to conduct my practice within the scope of practice of massage therapy in a competent, professional and ethical manner, and in accordance with all of the foregoing.

Dated this _____ day of _____ , 2017 in the city/town of _____, Manitoba.

Applicant: **Witness:**

_____   _____ _____
(Signature)   (Signature)

_____   _____ _____
(Name – please print)   (Name – please print)

INTERNAL USE ONLY

Date Received	Date Approved:	Signed: