



ABN 69 088 314 818

THE AUSTRALIAN REGISTER OF HOMOEOPATHS LTD

122 Church Street, Wollongong NSW 2500

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Web address: www.aroh.com.au

Application for Readmission to the Australian Register of Homoeopaths for 2010

Your current registration with AROH expires on 28 February, 2010. Please complete this registration form and return to AROH along with all accompanying documentation by 1st March 2010. Please allow 6 weeks from the time that all documentation has been received by AROH for your renewal to be processed.

Please DO NOT send this registration form without accompanying documentation and payment. Applications will not be processed until all documentation has been received.

Surname: Given Names: Title: D.O.B:

Clinic Address 1 Clinic Address 2

State: Postcode: State: Postcode:

Ph: Fax: Ph: Fax:

Mob: Email:

Postal Address (for AROH correspondence)

State: Postcode:

Ph: Fax: Email:

ANNUAL FEES - please note renewals are due by 28th February, penalties apply for late payment of fees
\$85 if all documents for renewal are received by 1 March 2010
\$110 if all documents for renewal are received by 1 April 2010
\$135 if all documents for renewal are received by 1 May 2010
\$165 for all renewals received after 1 May 2010

IF YOUR RENEWAL IS NOT RECEIVED BY 31 MAY 2010, YOU WILL BE REMOVED FROM THE REGISTER

Check List (No staples, pins or paper clips, thank you.) I have enclosed a copy of my:-

- Current First Aid Level II or Senior First Aid Certificate, which is no more than 3 years old and shows either completion or expiry date.
Professional Indemnity Insurance, showing expiry date, and Homoeopathy as a modality covered.
CPD Annual Record
Cheque/Money Order payable to the Australian Register of Homoeopaths Ltd for \$ being my renewal fee for the period ending 28th February 2011.
OR
I have arranged for direct transfer of \$ being my renewal fee for the period ending 28th February 2011, to the AROH Account, BSB 182-512, Account No. 960 856 193. Please ensure you quote your Surname, Initial & AROH registration number and forward a copy of the Bank's receipt for the transfer, with this application.
I give permission for AROH to make available my clinic details, including publication on the AROH Website.
I give permission for my details to be forwarded to the health insurance funds which recognise AROH as a provider, and understand that my file may be made available to an accredited auditor appointed by any of these health funds for the purposes of ensuring compliance with the Private Health Insurance (Accreditation) Rules'
I certify that I have read the AROH Standards of Practice document and that my clinic premises are compliant with those Standards.

Leave of Absence (Please refer to the Leave of Absence Policy on the AROH website.)

I wish to apply for leave of absence from AROH until / / . I include written notification as required by the Leave of Absence Policy.

I agree to be bound by AROH's rules, policies and procedures, including the Code of Professional Conduct, Standards of Practice, Guidelines for Continuing Professional Development and the Homoeoprophylaxis Guidelines as promulgated on AROH's website.

I certify that I have not been convicted of an indictable offence.

I agree to maintain the currency of my First Aid Certificate and Professional Indemnity Insurance, and to forward copies to AROH when they are renewed.

Signed Date