AUSTRALIAN REGISTER OF HOMŒOPATHS LTD
PO Box 1533 Warriewood Shopping Square NSW 2102
Phone: 0488 060 145
Email: admin@aroh.com.au
Website: www.aroh.com.au
ABN: 69 088 314 818

APPLICATION FOR RE-REGISTRATION
To the Australian Register of Homoeopaths (ARoH)

This application maybe completed and emailed with supporting documents (in a pdf format) to: admin@aroh.com.au
OR
posted to:

AROH Registrar
PO Box 1533
WARRIEWOOD SHOPPING SQUARE NSW 2102

STEP 1: Personal Details

Title:

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other (Specify)

Family name / Surname: _____

First /Given Name: _____

Middle name(s): _____

Previous name(s) /Maiden name: _____
(Please supply a certified copy of your Change of Name legal document if your qualifications certificate is present in another name)

Date of Birth: (dd/mm/yyyy) _____

Sex: ☐ Male ☐ Female

STEP 2: Contact Details

Postal/Mailing Address

_____

_____

_____

State: _____ Postcode: _____

Country: (If other than Australia) _____

Contact number

Phone: Business hours _____

Phone: After hours**:** (optional) _____

Email: _____

STEP 3: Clinic Details

Primary Clinic Address

_____

_____

State: _____ **Postcode:** _____

Additional Clinic Address (if applicable)

1. _____

   _____

   State: _____ **Postcode:** _____

2. _____

   _____

   State: _____ **Postcode:** _____

STEP 4: Educational Qualifications

Year of last registration with ARoH ……

Highest Homoeopathic Qualification: Please tick the relevant box

☐ Doctorate (Homeopathy)

☐ Master (Homeopathy)

☐ Bachelor (Homeopathy)

☐ Adv. Diploma (Homeopathy)

☐ Other

Highest Academic Qualification: Please tick the relevant box

☐ Doctorate Health Science ☐ Doctorate

☐ Master Health Science ☐ Masters

☐ Bachelor Health Science ☐ Bachelor

☐ Adv. Diploma

☐ Other

Studies undertaken since previous registration with ARoH

i. ……..

ii. ……

Qualification Details (NOTE: if the qualification is obtained overseas, it will need to be accredited by VETASSESS):

1. **Qualification**

   Title: _____

   Date of completion: _____

   Name of Institution (University/College/ Examining Body): _____

   Is the institution ARoH accredited? ☐ Yes ☐ No

   Country of Institution: _____

   If Australian, provide name of state: _____

   If Australian, provide the AQF level: _____

   Please provide certified* copy of the original academic transcript and qualification

   (*certified = by a Justice of Peace or relevant authorised notary)

2. **Qualification:**

   Title: _____

   Date of completion: _____

   Name of Institution (University/College/ Examining Body): _____

   Is the institution ARoH accredited? ☐ Yes ☐ No

   Country of Institution: _____

   If Australian, provide name of state: _____

   If Australian, provide the AQF level: _____

   Please provide certified* copy of the original academic transcript and qualification

   (*certified = by a Justice of Peace or relevant authorised notary)

Continuing Profession Development/Education (CPD)

List all homeopathic and non homeopathic educational activities since your last period of ARoH with registration

DATE	ACTIVITY	CPD HOURS	SUPPORTING DOCUMENT AVAILABLE

Add extra sheet for additional activities, Include as many as you can.

STEP 5: Professional Suitability Details

Do you have any criminal history in Australia? ☐ **No** ☐ **Yes**
If yes, please provide details on a separate sheet with explanation of circumstances

Do you have any criminal history in another country? ☐ **No** ☐ **Yes**
If yes, please provide details on a separate sheet with explanation of circumstances

Have you previously had any registration or professional association membership cancelled, refused or suspended in Australia or overseas? ☐ **No** ☐ **Yes**
If yes, please provide details on a separate sheet with explanation of circumstances

Have you ever been the subject of a complaint or notification to any health complaints organisation, professional association or similar? ☐ **No** ☐ **Yes**
If yes, please provide details on a separate sheet with explanation of circumstances

Do you have Professional Indemnity Insurance with a minimum of $2 million in cover for homoeopathy in any single claim?
☐ **No** ☐ **Yes**
If yes, please provide certified copy of current policy
If no, please provide details on a separate sheet with explanation. Please note that your application maybe rejected if you do not commit to having a Professional Indemnity Insurance.
Currently registered medical practitioners (AHPRA registered) need only supply proof of current medical registration and insurance

documentation.

Do you have a current First Aid Level II certificate?
☐ **No** ☐ **Yes**
If yes, please provide certified copy of current certificate
If no, please provide details on a separate sheet with explanation.
Currently registered medical practitioners (AHPRA registered) need only supply proof of current medical registration and insurance documentation.

STEP 7: Declaration

I declare that:

- ☐ that the above statements/ information and the documents provided in support of this application, are true and correct and
- ☐ I am the person named in the attached documents
- ☐ I make this declaration in the knowledge that a false statement is grounds for the Board to refuse registration
- ☐ I am aware that personal information I provide may be given to a third party for regulatory purposes, consistent with the National Law
- ☐ If there have been any events recorded in my criminal history, I have provided details to AROH of each such event (excluding traffic matters) including outside Australia, whether under the current or a previous name, and I undertake to report any future events, while I remain registered with AROH
- ☐ I hereby give permission for ARoH to release my clinic contact details.
- ☐ I will abide by ARoH's **Code of Professional Conduct, Standards of Practice, Guidelines for Continuing Professional Development and the Homoeoprophylaxis Guidelines,** as promulgated on ARoH.
- ☐ I agree to maintain the currency of my First Aid Certificate
- ☐ I agree to maintain my Professional Indemnity Insurance.
- ☐ I have enclosed/uploaded certified copies of all relevant documents (qualifications, statement of academic transcript, clinic logs, insurance, professional indemnity insurance)

Signed_____

Date _____

STEP 8: Payment Details

☐ Applying Feb – May **$210**
☐ Applying June – August **$180**
☐ Applying September - November **$150**
☐ Applying December - January **$120**
☐RCC – applicant fees - **$250** International applicant fees -**$550**

☐ Re-Registration **$60** (plus application fee according to the time of application).

Please note there is a non-refundable application fee of $50 if application is withdrawn and/or unsuccessful.

- ❑ Please make payment payable to the Australian Register of Homoeopaths for $_____ being my non-refundable application fee plus annual registration fee for the period ending 31st March 20_____
- ❑ I have arranged Direct Deposit to AROH BSB 182-512, Account No. 960 856 193, quoting my Surname and Initial. **Please enclose a copy of the Internet Transaction Receipt for the transfer. (ARoH preferred method of payment)**
- ❑ I enclose a cheque/money order payable to the Australian Register of Homoeopaths with my details

Email application form to admin@aroh.com.au