Chinese Medical Institute & Register
in association with Beijing University of Chinese Medicine

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Membership Application Form

Thank you for your interest in becoming a CMIR member and helping us to push forward a new paradigm of integrative healthcare by supporting Chinese medicine and CMIR. Please complete this form and return together with any supporting documentation by post to the above address. Please include copies of your qualifications, insurance certificate, professional registration with any other organisations, and two recent passport photos with your application. For membership fees and application fees, please see the table included at the end of the document.

Personal Details

Title:	Surname:
First Name:	
Date of Birth:	Sex: Male / Female
Permanent Address:	
Main Contact Number:	Other Contact Number:
Email Address:	

Professional Details

Current Organisation:
Current Job Title:
Organisation Address:
Telephone Number:
Email Address:

Professional Education and Experience

Please give details of any universities or colleges attended and degrees/diplomas obtained for which you have studied/are studying. If the date of your award is pending, please specify a future date of award.

Qualification	Level	Institute Name and Address	Date Obtained

* Please continue on a separate sheet of paper if necessary

Please give details of your last 5 years of employment, starting with your current employer.

Job Title	Employer Name	Employer Address	Dates

* Please continue on a separate sheet of paper if necessary

Other Professional Membership

Please give details of any other professional organisations you belong to.

Organisation Name and Address	Membership Number and Category	Expiry Date

* Please continue on a separate sheet of paper if necessary

References

Please give the names and contact details of two references, who have known you for at least 2 years. At least one of your references should have experience of working with you in a professional capacity.

Title:	Surname:
First Name:	
Permanent Address:	
Main Contact Number:	Other Contact Number:
Email Address:	
In what capacity do you know the applicant?	

Title:	Surname:
First Name:	
Permanent Address:	
Main Contact Number:	Other Contact Number:
Email Address:	
In what capacity do you know the applicant?	

CMIR Membership

I would like to apply for:

- ☐ Associate Membership
- ☐ Accredited Membership
- ☐ Specialist Accredited Membership
- ☐ Chinese Medicine Physician Membership

Membership to start from 1st _____ (Month) _____ (Year)

For more information on the different types of membership, please call 0207 388 6704 or email membership@cmir.org.uk.

Please be aware you may be requested to attend an interview and / or competence assessment as part of the application process. You will be informed by CMIR if you need to attend.

Declaration

Have you ever been convicted of any criminal offence in any court in UK or abroad?

☐ Yes Please give details: _____

_____

☐ No

☐ *If you have a DBS reference number, please provide it here :* _____

Have you ever been refused or expelled from membership of any other professional body or register on the grounds of professional misconduct or other professionally related offence?

☐ Yes Please give details: _____

_____

☐ No

Have you ever been the subject of any professionally related disciplinary action (which may or may not have ended in dismissal)?

☐ Yes Please give details: _____

_____

☐ No

Are you suffering from or have you suffered from any disease in the past two years, which affects your performance or judgment?

☐ Yes Please give details: _____

_____

☐ No

Are you registered disabled?

☐ Yes Please give details: _____

_____

☐ No

Completion and Submission of Application

- ☐ I pledge to abide by the CMIR Code of Conduct and Good Practice as laid out in the CMIR Professional Handbook for Members
- ☐ I pledge to meet all necessary reaccreditation criteria as laid out in the CMIR Professional Handbook for Members
- ☐ I pledge to carry out my duties in a professional and ethical way and behave with integrity and honesty at all times
- ☐ I confirm that I have current, valid practice indemnity insurance cover
- ☐ I confirm that my English language proficiency allows me to maintain proper and effective communication with my patients
- ☐ I confirm that the statements I have made on this form are true and accurate

Signed: _____ Date: _____

After receiving approval of your application, please submit an application fee of £50 and the relevant membership fee, listed in the following table:

Starting Date	**End date**	**Fees**
Jun 1st to Jun 30th	May 31st (The following year)	£75 + VAT
July 1st to July 31st	May 31st (The following year)	£68.75 + VAT
Aug 1st to Aug 31st	May 31st (The following year)	£62.5 + VAT
Sept 1st to Sept 30th	May 31st (The following year)	£56.25 + VAT
Oct 1st to Oct 31st	May 31st (The following year)	£50 + VAT
Nov 1st to Nov 30th	May 31st (The following year)	£43.75 + VAT
Dec 1st to Dec 31st	May 31st (The following year)	£37.5 + VAT
Jan 1st to Jan 31st	May 31st	£31.25 + VAT
Feb 1st to Feb 28th	May 31st	£25 + VAT
Mar 1st to Mar 31st	May 31st	£18.75 + VAT
Apr 1st to Apr 30th	May 31st	£12.5 + VAT
May 1st to May 30st	May 31st	£6.25 + VAT