ASSOCIATION OF HEARING INSTRUMENT PRACTITIONERS OF ONTARIO

Membership Application

STUDENT MEMBER **$ 75.00**

Payment: Cheque____ MC/ Visa/Amex_____Exp: _____ CVVcode :____
Credit card only – not credit/debit card)

A. APPLICANT INFORMATION

PLEASE PRINT CLEARLY

_____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

_____
COMPLETE HOME ADDRESS (Incl. Postal Code)

_____ _____
CELL or HOME PHONE # DATE OF BIRTH (DD/MM/YYYY)

_____
MEMBER CONTACT EMAIL ADDRESS*(mandatory)*****

B. EDUCATION

PLEASE INDICATE ANY COLLEGE OR UNIVERSITY EDUCATION AQUIRED OR ATTENDING AT PRESENT.

NAME OF INSTITUTE	PROVINCE (LOCATION)	YEARS COMPLETED	DEGREE	MAJOR SUBJECTS	COMPLETION DATE

C. EMPLOYMENT

BEGIN WITH YOUR PRESENT PLACE OF EMPLOYMENT. LIST **EVERY** POSITION HELD FOR THE PAST 5 YEARS

NAME & COMPLETE ADDRESS OF EMPLOYER	DATES OF EMPLOYEMENT FROM____ TO____	DUTIES	FULL OR PART TIME	NAME & TITLE OF SUPERVISOR	REASON FOR LEAVING

D. REFERENCES

REFERENCES:

1. COMPANY_____

ADDRESS_____

PHONE _____

2. COMPANY_____

ADDRESS_____

PHONE _____

APPLICANT'S AFFIDAVIT

I hereby make application for membership in the Association of Hearing Instrument Practitioners of Ontario, and if accepted, I will abide by the By-Laws, Policies and Code of Ethics as established by the Association. I understand that failure to do this may be cause for cancellation and recall of my Certificate and expulsion from the Association. I further understand that continuance of my Membership is conditional upon my meeting the requirements for annual renewal of my Certificate.
I acknowledge that the Certificate of Membership is the property of the Association and that it will be returned upon demand by the Association.

_____ _____

SIGNATURE **DATE**

PLEASE MAIL or FAX COMPLETED APPLICATION FORM TO:
ASSOCIATION OF HEARING INSTRUMENT PACTITIONERS OF ONTARIO,
55 MARY STREET WEST, SUITE # 211,
LINDSAY, ONTARIO, K9V 5Z6.
FAX # 705-878-4110 or 1-844-688-5583

PLEASE INCLUDE PAYMENT FOR YOUR MEMBERSHIP DUES.
PROCESSING YOUR APPLICATION MAY TAKE UP TO 2-3 WEEKS. WHEN YOUR APPLICATION IS APPROVED, YOU WILL RECEIVE OFFICIAL NOTIFICATION BY MAIL FROM AHIP.
FAILURE TO COMPLETE THE APPLICATION WILL DELAY PROCESSING

THIS SECTION FOR OFFICE USE ONLY- DO NOT WRITE IN THE SPACE BELOW

DATE RECEIVED: _____ **APPROVED BY:** _____

MOTION DATE: _____ **MEMBERSHIP #:** _____