Membership Application 2016 for Occupational Therapists

I wish to apply for membership of WA Occupational Therapy Association (Inc) and I agree to accept and abide by the ethics and constitution. If you do not agree to your work details being published on the WA Occupational Therapy Association (Inc) Website (Members Only Access) please tick this box. ❑

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

Surname …… First Name ……

Previous Name …… Year of Birth……

Postal Address ……

…… Post Code ……

Tel. Home ……Fax …… Mobile ……

Email ……

For Office Use Only:
❒ Renewal ❒ Lapsed (year _____)
❒ New member

MEMBERSHIP CATEGORY

Please indicate your membership category for 2016 by **CIRCLING** the amount in the table below. Your registration number or a copy of your qualifications for verification should be included with your application if you have not previously supplied them. ☐ **Copy of Qualifications Enclosed**

Membership Category	**Early Bird***	**Standard Fee**
Full-Time *(Working more than 20 hours PW)*	$360	$430
Part-Time *(Working 1 – 19 hours PW)*	$335	$405
Non-Working	$335	$405
Graduate (must have been student member of WA Occupational Therapy Association in 2015	$255	$315
Students		
1st Year Undergraduate/1st Year MOT	FREE	FREE
2nd Year Undergraduate	$80	$100
3rd Year Undergraduate	$80	$100
4th Year Undergraduate/2nd Year MOT	$80	$100

Office Use Only

***EARLY BIRD PAYMENTS MUST BE PAID IN FULL BY 29th JANUARY 2016 (Instalment Plan Not Available)**

PAYMENT METHOD

Membership is for the calendar year, January to December and cannot be cancelled during the year and is non-refundable. As a service for those paying by CREDIT CARD a quarterly payment option is provided. Your signature is an agreement to continue the payments for the whole year. Payments will be deducted on joining, at the end of March, June and September.

☐ **Quarterly instalment option – Credit Card only –THERE IS A $10 ADMIN FEE ATTACHED TO INSTALMENTS**

☐ **Cheque enclosed** – Full Payment

☐ **Credit Card** – Full or Quarterly Payment – following is my authority to debit my **Visa / Mastercard:**

☐☐☐☐/☐☐☐☐/☐☐☐☐/☐☐☐☐

Signature …… Expiry Date ……

Card Holder Name ……

Please make sure that you sign the declaration on page 4 and return form to: WA Occupational Therapy Association Inc, 4A/266 Hay Street, SUBIACO WA 6008, E-mail: info@waota.com.au or Fax: (08) 9388 1492

Expertise

Please circle from the list below for area of expertise or interest: <u>choose 5 maximum</u>

(Private Practitioners – please note that the following will also be used as the key words for website entry)

Key	Expertise
AC	Access
AG	Aged Care
AL	Alzheimers
AM	Acute Medicine
AMPS	Assessment of Motor & Process Skills
AP	Acute Psychiatry
AT	ACAT (Aged Care Assessment Team)
BU	Burns
CA	Cardiac
CD	Community Development
CE	Cerebrovascular
CO	Counselling
CP	Cerebral Palsy
CS	Child Psychiatry
DD	Developmental Delay
DI	Disability
DP	Disability Physical
DR	Driver Assessment & Rehabilitation
ED	Education
ER	Ergonomics
ET	Ethics
EQ	Equipment
GE	Gerontology
GM	General Medicine
GS	General Surgical
HA	Hand & Upper Limb
HD	Head Injuries
HM	Home Modification
HP	Health Promotion
HV	Home Assessment/Visiting
IM	Injury Management Prevention
LD	Learning Disability

Key	Expertise
LY	Lymphoedema Management
MA	Manutention
MG	Management
MH	Mental Health
ML	Medico-Legal
NE	Neurosciences
NU	Neurology
OH	Occupational Health & Safety
ON	Oncology
OP	Orthopaedics
PA	Palliative care
PC	Primary Care
PE	Paediatrics
PG	Psychogeriatrics
PH	Public Health
PM	Pain Management
PR	Psychosocial Rehabilitation
PS	Psychiatric Rehabilitation
PW	Project Work
PY	Psychiatry
RE	Physical Rehabilitation
RH	Research
RU	Rheumatology
RP	Rural Practice
SE	Seating
SI	Sensory Integration
SM	Stress Management
SP	Splinting
ST	Soft Tissue Therapy
VI	Vision Impairment
VO	Volunteers
VR	Vocational Rehabilitation

Current Local Interest Group Membership ……

I certify that all information furnished in this document is true and accurate in every respect. I certify that I have not been refused membership of any Occupational Therapy Association, nor registration, in Australia or overseas. I agree to abide by the WA Occupational Therapy Association Inc (formerly OT AUSTRALIA WA) Memorandum & Articles of Association and OT AUSTRALIA Code of Ethics.

Signed ……..……..

'Find an OT' Website Entry for Private Practitioners Only

Private Practice (Please complete this section IN FULL – details not submitted will not be included)

Name of Practice ..……...

Name of OT ……..…..

Address and contact details to use for website entry only. Indicate whether the same as 1A. or 1B. or as below:

Address ……..……..

Suburb …… Postcode …….

Phone ……..…… Fax ……..…… Mobile ……..……

Email ……..…… Website…..……..……

Please tick ALL relevant categories below:

Services:

- ☐ Rooms
- ☐ Home Visits
- ☐ Hospital
- ☐ Nursing Home Visits
- ☐ School/Day Care Visits
- ☐ Mobile Only Service

Approved Provider:

- ☐ Registered for Medicare
- ☐ Better Access to Mental Health Care Provider
- ☐ EPC (Enhanced Primary Care)
- ☐ PDD (Pervasive Developmental Disorder)
- ☐ FPS (Focused Psychological Strategies)
- ☐ APSP (Approved Autism Panel Service Provider)
- ☐ ASD (Autism Spectrum Disorder)
- ☐ HICAPS/eclaiming
- ☐ DVA (Department of Veteran Affairs)

Client Group:

- ☐ Workers Compensation
- ☐ Motor Vehicle Accident
- ☐ Privately Insured

Client Age Group:

- ☐ Babies
- ☐ Children
- ☐ Adolescents
- ☐ Adults
- ☐ Older Adults
- ☐ All
- ☐ N/A

Keywords are listed overleaf

Qualifications

OT Registration Board No. / National Registration Board No......

Original date of registration .....

Qualification Type	Date of Qualification	Institution

Membership Database Update

1A. Work Details

Organisation ……..…..
Department ……..…….. Position Held ……..…..……
Address ……
Suburb ……Postcode ……
Phone ……..…… Fax ……..…… Mobile ……..……
Email ……..…… Website ……..……..

1B. Additional Work Details

Organisation ……..…..
Department ……..…….. Position Held ……..…..……
Address ……
Suburb ……..Postcode ……
Phone ……..…… Fax ……..…… Mobile ……..……
Email ……..…… Website ……..……

2. Work Category

☐ Clinician ☐ Manager/Clinician ☐ Other ……
☐ Clinical/Researcher ☐ Educator/Teacher ☐ None ……
☐ Educator/Researcher ☐ Manager/Administrator

3. Work Sector

☐ Public ☐ Private - Not for Profit ☐ None ……
☐ Private – Profit ☐ Other ……

4. Work Setting

Hospital:

☐ Acute Hospital Inpatient
☐ Acute Hospital Outpatient/Ambulatory
☐ Sub-Acute Hospital Rehab Inpatient
☐ Sub-Acute Hospital Outpatient

Community:

☐ Community Health Service
☐ Community Mental Health
☐ Day Care Centre
☐ Disability Services (DCS, SC, MS, PDSS)
☐ Domiciliary Care Services
☐ Residential, Retirement Living, Accommodation Services
☐ Vocational Rehabilitation, Injury Prevention (Non-hospital/Industry)

Private Practice:

☐ Private Practice Rooms
☐ Private Practice (Home-Based)

Education:

☐ Pre-School Education Services
☐ Schools Education Services
☐ Tertiary Education Services
☐ Community Education

Industry:

☐ Industry or Business Sector

Other:

☐ Other Government (Policy, Non-Clinical) ☐ Other ……..... ☐ None

5. Client Age

☐ 0-17yrs child and adolescent ☐ 18-65yrs (working) ☐ All ages
☐ 18+yrs (adult) ☐ 65+yrs (older adult) ☐ Not applicable