



## Membership Application 2017 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 2017 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	Office Use Only
Full-Time ( <i>Working more than 20 hours PW</i> )	\$360	\$430	
Part-Time ( <i>Working 1 – 19 hours PW</i> )	\$335	\$405	
Non-Working	\$335	\$405	
Graduate - (must have been student member - excl 3 <sup>rd</sup> Year MOT of WA Occupational Therapy Association in 2016)	\$255	\$315	
<b>Students</b>			
1 <sup>st</sup> Year Undergraduate/1 <sup>st</sup> Year MOT	FREE	FREE	
2 <sup>nd</sup> Year Undergraduate	\$80	\$100	
3 <sup>rd</sup> Year Undergraduate	\$80	\$100	
4 <sup>th</sup> Year Undergraduate/2 <sup>nd</sup> Year MOT	\$80	\$100	
3 <sup>rd</sup> Year MOT	\$170	\$210	

**\*EARLY BIRD PAYMENTS MUST BE PAID IN FULL BY 27th JANUARY 2017 (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 2 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: **choose 5 maximum**

(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 .....

**Privacy Statement**

WA Occupational Therapy Association Inc is committed to supporting the National Privacy Principles. We will only collect and store information about you that is necessary. The information you provide may be used to offer, provide and improve our services to you and may also be disclosed to other parties such as organisations contracted to operate and maintain WA Occupational Therapy Association databases and distribute WA Occupational Therapy Association information. We will not otherwise, without your consent, use or disclose the information you provide for any other purposes unless it would reasonably be expected that such a purpose is related to the offer, provision and improvement of WA Occupational Therapy Association Inc services and benefits to you or where such purpose is permitted or required by law. You are entitled to request reasonable access to the information we hold about you.

## '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:**

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Rooms       | <input type="checkbox"/> Nursing Home Visits    |
| <input type="checkbox"/> Home Visits | <input type="checkbox"/> School/Day Care Visits |
| <input type="checkbox"/> Hospital    | <input type="checkbox"/> Mobile Only Service    |

**Approved Provider:**

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

**Client Group:**

- Workers Compensation
- Motor Vehicle Accident
- Privately Insured

**Client Age Group:**

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Babies      | <input type="checkbox"/> Older Adults |
| <input type="checkbox"/> Children    | <input type="checkbox"/> All          |
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> N/A          |
| <input type="checkbox"/> Adults      |                                       |

**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

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Clinician           | <input type="checkbox"/> Manager/Clinician     | <input type="checkbox"/> Other ..... |
| <input type="checkbox"/> Clinical/Researcher | <input type="checkbox"/> Educator/Teacher      | <input type="checkbox"/> None .....  |
| <input type="checkbox"/> Educator/Researcher | <input type="checkbox"/> Manager/Administrator |                                      |

## 3. Work Sector

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Public           | <input type="checkbox"/> Private - Not for Profit | <input type="checkbox"/> None ..... |
| <input type="checkbox"/> Private – Profit | <input type="checkbox"/> Other .....              |                                     |

## 4. Work Setting

### **Hospital:**

- |   |   |
|---|---|
| <input type="checkbox"/> Acute Hospital Inpatient             | <input type="checkbox"/> Sub-Acute Hospital Rehab Inpatient |
| <input type="checkbox"/> Acute Hospital Outpatient/Ambulatory | <input type="checkbox"/> Sub-Acute Hospital Outpatient      |

### **Community:**

- |  |   |
|--|---|
| <input type="checkbox"/> Community Health Service                | <input type="checkbox"/> Residential, Retirement Living, Accommodation Services               |
| <input type="checkbox"/> Community Mental Health                 | <input type="checkbox"/> Vocational Rehabilitation, Injury Prevention (Non-hospital/Industry) |
| <input type="checkbox"/> Day Care Centre                         |   |
| <input type="checkbox"/> Disability Services (DCS, SC, MS, PDSS) |   |
| <input type="checkbox"/> Domiciliary Care Services               |   |

### **Private Practice:**

- |   |  |
|---|--|
| <input type="checkbox"/> Private Practice Rooms | <input type="checkbox"/> Private Practice (Home-Based) |
|---|--|

### **Education:**

- |  |  |
|--|--|
| <input type="checkbox"/> Pre-School Education Services | <input type="checkbox"/> Tertiary Education Services |
| <input type="checkbox"/> Schools Education Services    | <input type="checkbox"/> Community Education         |

### **Industry:**

- Industry or Business Sector

### **Other:**

- |  |                                      |                               |
|--|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Other Government (Policy, Non-Clinical) | <input type="checkbox"/> Other ..... | <input type="checkbox"/> None |
|--|--------------------------------------|-------------------------------|

## 5. Client Age

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 0-17yrs child and adolescent | <input type="checkbox"/> 18-65yrs (working)   | <input type="checkbox"/> All ages       |
| <input type="checkbox"/> 18+yrs (adult)               | <input type="checkbox"/> 65+yrs (older adult) | <input type="checkbox"/> Not applicable |