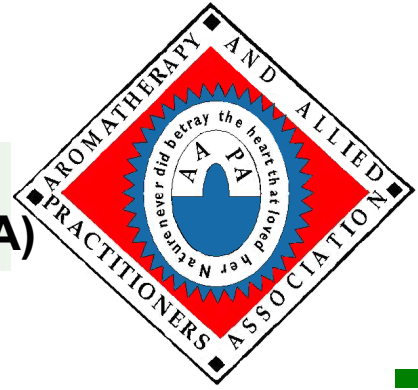


Your therapy family

THE AROMATHERAPY & ALLIED PRACTITIONERS' ASSOCIATION (AAPA)



STUDENT MEMBERSHIP APPLICATION FORM 2009/2010

Title	MR MS MRS MISS DR (PLEASE CIRCLE)
First Name	
Surname	
Address	
Town/City	
County	
Postcode / Country	

Telephone Numbers:	Home	Mobile
Email address		
Date of Birth:		
Details of course being undertaken		
Training College Name		
Training College Address		
Are you insured to practice:	YES / NO <i>(attach photocopy of insurance certificate) We will send you details of our own scheme if no</i>	
Other therapies you are qualified in <i>You may require full membership if you hold existing qualifications especially for insurance purposes</i>		

Before returning your documents, please check you have enclosed the following:

- Your cheque for student membership
- A copy of your insurance certificate if you are already insured
- A copy of any certificates for therapies already qualified in

RETURN TO: The AAPA
PO Box 36248
London SE19 3YD

PLEASE COMPLETE THIS SECTION

Subscription 2009-10 **£20.00**
(for life of course)

Total to be remitted by cheque please **£20.00**

Cheques to be made payable to the AAPA