

The Society of Chiropodists and Podiatrists of Ireland Ltd.

Secretary's Office: 68 Granville Road, Dun Laoghaire, Co. Dublin.

Tel: 01 2024939 Fax: 01 2847230 Email: maxwellj@eircom.net

MEMBERSHIP APPLICATION FORM

Please use block letters throughout.

| | | |
|--|--------------------------|---|
| Surname: | | Title: (Mr/s, Ms, Dr, etc.) |
| First name(s): | | |
| Private address: | | |
| Telephone number: | | Fax number: |
| Mobile: | | |
| E-mail: | | Date of birth: |
| Practice address(es): | | |
| Telephone number: | | Fax number: |
| E-mail: | | Year of qualification: |
| School of training: | | Specialisms: |
| Qualification(s) obtained: | | |
| Type of intended employment: <i>Please tick</i> | <input type="checkbox"/> | Private practice |
| | <input type="checkbox"/> | Private practice with Medical Card patients |
| | <input type="checkbox"/> | Employed directly by Health Board |
| | <input type="checkbox"/> | Combination of the above |
| Is Chiropody / Podiatry your sole occupation? <i>If 'No' please specify.</i> | | Yes / No <i>Please delete as appropriate.</i> |
| Signature of applicant: | | Date of application: |

Applicants must be graduates of a recognised School of Podiatry.

If you are a member of the UK Society of Chiropodists and Podiatrists please insert your membership registration number

This form should be completed and returned to the Secretary's Office accompanied by the annual subscription. Evidence of qualification should also be attached.

Method of payment

Cash Cheque Postal Order

Please tick as appropriate