

Please mail back this form to AAQ HEAD OFFICE: 1453, rue Beaubien Est, suite 203 Montréal, QC H2G 3C6

Name and surname : _____

Date of birth : _____ / _____ / _____

OAQ Licence #No : _____ (for acupuncturists only)

Membership status** : _____ Annual Fee : _____ \$

- **Status active acupuncturists registered at the «Ordre des acupuncteurs du Québec » OAQ **247.20\$** (215\$ + taxes)
- New graduate acupuncturists registered at the OAQ & for the first 2 years post-graduation **178,21\$** (155\$ + taxes)
- Parental leave parental status for 1 year preceding or following birth or adoption of child **132.22\$** (115\$ + taxes)
- Inactive sabbatical year, retired, off year, sick leave, maternity leave **86.23\$** (75\$ + taxes)
- Student student in acupuncture (with proof of study) 50\$ per year or 75\$ duration of studies (taxes included)
- Supporters supporting members (public: clients, supporter of TCM) 50.00\$ (taxes included)

Mailing and Contact Coordinates (for internal use of the AAQ only)

Mailing Address: _____

City : _____

Postal Code : _____ Province: _____

Phone (1) : _____ Phone (2): _____

EMAIL FOR AAQ communication: _____

Referral Services of the AAQ YES please include your clinical coordinates below NO

CLINICAL COORDINATES

	Clinique #1	Clinique #2	Clinique #3
Other name of Clinic			
Region of Québec :			
Address :			
City :			
Postal Code:			
Borough :			
Phone(s) :			
EMAIL for the public:			
WEB SITE :			
OTHER INTERESTS OF YOUR CLINIC Home visits, Laser, Qi Gong, Tui Na, Herbs, or other clinical interest of your practice			

»»»»»»»»» PLEASE READ AND SIGN BELOW ««««««««««

I assert that the information on this form is true and accurate. I understand that it is my responsibility to notify the AAQ in writing of any changes. I understand that the AAQ cannot be held liable for any act of omission or statement on my part. I agree that the AAQ may use my contact information for internal management purposes such as, to contact me, offer services, collect my dues, etc. Only members of the administrative board, authorized volunteers or staff of the AAQ will have access to my information as part of their duties.

In regards to the AAQ referral lists: If I consent to appear on the referral lists of the AAQ, I understand that I hereby give permission to the Association of Acupuncturists of Quebec to share and publish my clinical details to the public. I understand that this referral service is available exclusively to the AAQ members licensed to practice acupuncture in Quebec I therefore affirm that I am a member in good standing with the OAQ (Ordre des acupuncteurs du Québec / Quebec Order of Acupuncturists) and have complied with all the conditions required for this purpose. I understand that the AAQ reserves the right to exclude any member from its referral services who is deemed not complying with the professional requirements of the OAQ or who has not kept their AAQ membership up to date.

SIGNATURE REQUIRED

DATE