2012-13 Membership Application (Page 1 of 3)

SAOT
Society of Alberta Occupational Therapists

Please read carefully and send completed form along with payment to:
14035-105 Ave. NW, PO Box 53079, Edmonton, AB T5N 0Z1 Fax: (780) 401-3314

□ New □ Renewal

First Name ________________________________ Last Name _________________________________ Membership # _________

□ I am a full-time[1] occupational therapist in Alberta. **Full-time fees are $150 + 5% GST = $157.50.**

□ I am a part-time[2] occupational therapist in Alberta. **Part-time fees are $120 + 5% GST = $126.00.**

□ I graduate between March 1, 2012 – February 28, 2013[3] and am a new occupational therapist or provisional occupat therapist. **New graduate fees are $75 + 5% GST = $78.75.**

□ I am a non-practicing occupational therapist[4]. **Non-Practicing fees are $50 + 5% GST = $52.50.**

□ I am an entry-level occupational therapy student studying at ___________________________________

and I expect to graduate in __________, 20____. **Student membership is free to entry-level OT Students!**

□ Pro-rated fees (if registering after October 2010). **$75 + GST = $78.75.**

[1] Full-time status is practicing greater than 800 hours per year [2]Part-time status is practicing 800 hours per year or less

[2]Graduates must provide proof of graduation (ie. photocopy of degree certificate) or proof of eligibility to graduate. [4]Non-practicing applicants must provide proof of graduation from a WFOT accredited occupational therapy program or past registration from a Canadian occupational therapy regulator.

Home Address: ____________________________________ City: ______________________ Postal Code: ________________

Home Ph: (_____)____________________ Work Ph: (_____)____________________ Fax: (_____)_____________________

Email: ____ Email is the primary communication method of SAOT.

Occupational Therapists – Practice Setting (please check all that apply):

□ Hospital-based physical medicine
□ Hospital-based mental health
□ Home care
□ Community mental health
□ Rehabilitation facility
□ Continuing care facility
□ Community pediatrics
□ School-based practice
□ Occupational rehabilitation
□ Medical-legal
□ Academic/research/teaching
□ Leadership/management

Other categories (please describe practice):
□ Consulting ___________________________________
□ Private clinic ________________________________
□ Other _______________________________________

Optional:

□ I want to purchase professional liability insurance from HDF Insurance (if yes, please read carefully and complete page 3)

□ Yes, I consent to my name and the following contact information

□ Email-address □ Preferred mailing address

being shared with vendors offering services, products, or seminars of interest to occupational therapists. I understand that SAOT screen as much as possible, recipients of this information, but is not responsible for such vendors' use of this information.

□ I have an interest in receiving mentorship from other SAOT members?

If you checked yes: In what area(s) would you like to receive mentorship? ____

□ Do you have interest in being a potential mentor for other SAOT members?

If you checked yes: What is your area of practice / specialty / expertise? ____

How long have you been in this area? _____________ Where do you live/practice? __________________________________

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Verification :
*Membership fees are **non-refundable** and **non-transferable** based on the application date. The membership year is March 1, 2012 to February 28, 2013. All the information appearing on this Application Form is accurate to the best of my knowledge.*

Signature of Applicant: ______________________________________ Date: _________________________________

Payment Method:
□ Cheque/Money order payable to "SAOT" □ Please bill my credit card for my membership fees: □ Visa □ Mastercard

Cardholder name: ___________________ Card Number: _ _ _ _ / _ _ _ _ / _ _ _ _ / _ _ _ _

Exp. Date _____ / _____ Signature: _____________________________ Date: ________________________________

Note: This is the end of the SAOT Membership Application. Please proceed to page 3 if you require professional liability insurance.

Thank you for supporting occupational therapy in Alberta!

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First Name ________________________________ Last Name ______________________________

□ I am a SAOT member, or have applied for membership, and am an occupational therapist registered with the Alberta College of Occupational Therapists, and I want to purchase a personal policy of the SAOT – HDF Insurance Professional Liability Insurance. If already a member, my membership number is: ________

Policy is $75.00* for coverage from March 1, 2012 – February 28, 2013. This period coincides with SAOT membership.

Signature: ____________________________ Date: __________________

A representative from HDF Insurance will forward a copy of your insurance certificate and the information required for ACOT renewal directly to you with the contact information you provided on your membership application. A copy of the insurance policy wording is available by contacting HDF Insurance directly:

Dave Douglas, HDF Insurance & Financial Group
Energy Square 10109 106 Street
Edmonton, Alberta T5J 3L7
Tel: (780) 488-0921 Fax: (780) 488-1633
Toll-Free Tel: (800) 567-2048 Fax: (800) 486-2966
Email: dave.douglas@HDFinsurance.com
www.HDFinsurance.com

Payment Method:
□ Cheque/Money order payable to "HDF Insurance" □ Please bill my credit card for $70.00 □ Visa □ Mastercard

Cardholder Name: ______________________ Card Number: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Exp. Date ___ / ___ Signature: __________________ Date: ________________

Optional:

□ I am interested in receiving information on HDF Insurance's commercial liability programs.

□ I am interested in receiving information on HDF Insurance's group extended health, disability, and life insurance programs.

□ I am interested in receiving information on HDF Insurance's group auto and home insurance programs.

A representative from HDF Insurance will contact you directly regarding any inquiries for additional insurance.