



## 2012-13 Membership Application (Page 1 of 3)

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<sup>1</sup> occupational therapist in Alberta. **Full-time fees are \$150 + 5% GST = \$157.50.**
  - I am a part-time<sup>2</sup> occupational therapist in Alberta. **Part-time fees are \$120 + 5% GST = \$126.00.**
  - I am I graduate between March 1, 2012 – February 28, 2013<sup>3</sup> and am a new occupational therapist or provisional occupational therapist. **New graduate fees are \$75 + 5% GST = \$78.75.**
  - I am a non-practicing occupational therapist<sup>4</sup>. **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!**
- <sup>1</sup> Full-time status is practicing greater than 800 hours per year    <sup>2</sup>Part-time status is practicing 800 hours per year or less  
<sup>2</sup>Graduates must provide proof of graduation (ie. photocopy of degree certificate) or proof of eligibility to graduate.<sup>4</sup>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):**
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hospital-based physical medicine | <input type="checkbox"/> Community pediatrics        | Other categories (please describe practice):<br><input type="checkbox"/> Consulting _____<br><input type="checkbox"/> Private clinic _____<br><input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hospital-based mental health     | <input type="checkbox"/> School-based practice       |  |
| <input type="checkbox"/> Home care                        | <input type="checkbox"/> Occupational rehabilitation |  |
| <input type="checkbox"/> Community mental health          | <input type="checkbox"/> Medical-legal               |  |
| <input type="checkbox"/> Rehabilitation facility          | <input type="checkbox"/> Academic/research/teaching  |  |
| <input type="checkbox"/> Continuing care facility         | <input type="checkbox"/> Leadership/management       |  |

**Optional:**

- I want to purchase professional liability insurance from HDF Insurance (if yes, please read carefully and complete page 3)
- I want to be listed in the private practice listing (SAOT will contact you for more information)
- 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? \_\_\_\_\_

**\* Pages 2 & 3 not applicable to students.**