



# Membership renewal 2024–2025

Due by 30 June 2024

## Member details

Title:  Mr  Mrs  Ms  Miss  Dr  Other Gender: \_\_\_\_\_ Date of birth: \_\_\_\_\_

First name: \_\_\_\_\_ Middle name: \_\_\_\_\_ Surname: \_\_\_\_\_

Full residential address: \_\_\_\_\_

Full postal address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

- Please tick if you DO NOT grant permission to the AHA to contact you by email.
- Professional members: please tick if you DO NOT grant permission to the AHA to update ARoH with any changes to your contact, clinic, insurance or first aid certificate details in the case that you notify the AHA of such changes.
- In the event of my admission as a member**, I agree to be bound by and observe the provisions of the Association's policies and by-laws. I declare that I have not been convicted of an indictable offence and I am not insolvent.

**In the case of professional membership**, I declare that I do not have an impairment that affects my ability to practise in the profession. I agree to be bound by:

- the AHA's Code of Ethics & Practice (CoEP), as published on the AHA website: <https://homeopathyoz.org>;
- ARoH's Code of Professional Conduct and Standards of Practice;
- the Australian laws and provisions regulating CM professions, including those formulated by the Therapeutic Goods Administration (TGA) as published on the TGA website;
- the National Code of Conduct for Unregistered Health Practitioners applicable in my State.

I acknowledge that in the event of professional conduct issues arising in respect to breaches of the AHA CoEP, or any of the above; disciplinary action or deregistration by ARoH; or complaints made against me; I will be subject to the AHA's complaints and disciplinary procedures and penalties that may be imposed.

I certify that the information supplied by me in this membership application is true and correct:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Annual membership fees (including GST) for year ending 30 June 2025

Clinic listings of professional members who have not renewed by 30 June 2024 will be removed from the AHA website until payment is received.

Memberships	Pay by 30 Jun 2024	Pay by 15 Aug 2024	Pay by 30 Sep 2024
Professional member	\$380	\$410	\$440
Professional member (1st year AROH reg.)	\$240	\$260	\$280
Professional member (2nd year AROH reg.)	\$290	\$315	\$340
General member	\$195	\$215	\$235
CAM student with Similia/newsletter hard copy*	\$60	\$66	\$72

- Student\***: I enclose a copy of this year's receipt (or letter or enrolment) from my college as evidence that I am currently a student. I am studying  on/  off campus (tick both if both apply) and expect to complete my studies in (modality): \_\_\_\_\_ by: \_\_\_\_\_ (year & month if known).

## Payment details

I have enclosed a cheque/money order for amount: \$ \_\_\_\_\_ (payable to: "AHA Inc") **OR**

Please debit my credit card:  Mastercard  Visa  AMEX Amount: \$ \_\_\_\_\_

Card number: \_\_\_\_\_ Expiry date: \_\_\_\_\_ 3-digit security code: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

Cardholder name: \_\_\_\_\_ Signature: \_\_\_\_\_

**You can renew online!**  
**Otherwise, return this form with your payment to:**  
 AHA National Office  
 1 Undercliff Road  
 FRESHWATER  
 NSW 2096  
 Ph: 0421 672 023

## Professional member (registered with ARoH)

- I request that my clinic details be included on the AHA website & referral listings for access by the public.  
**NOTE:** Clinic name and street address will not be published. NO AHA CHARGES apply for additional clinics.

### Clinic 1 details:

Clinic name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Website: \_\_\_\_\_

### Clinic 2 details:

Clinic name: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Website: \_\_\_\_\_

Please add the details of any further clinic/s overleaf.