# my abmp student membership application

**Please print all information IN BLUE or BLACK INK.**
**Incomplete application forms cannot be processed.**


**We're there for you.**
**ABMP. expectmore.**
1271 sugarbush drive,evergreen, colorado 80439-9766
telephone: 800/458-2267 fax: 800/667-8260


## 1. my personal information

Legal Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: ( ) _____

Date of Birth: _____-_____-_____
Month Day Year

E-mail: _____

Sex: ❑ M ❑ F

## 2. my referral credit

School Name/ABMP ID # _____

_____

Referral Credit will be awarded to a student's school when the ABMP Student member upgrades to Certified, Professional, or Practitioner level of membership.

## 3. my training

School Name: Oregon School of Massage

School's ABMP ID Number: 102354

City: Portland

State: OR Zip: 97301

Phone: ( 503 ) 244-3420

Length of Course: 555 hours

Start Date: _____

Completion Date: _____

**ABMP student membership provides liability insurance coverage only while you are enrolled in school. If your training lasts more than a year, you can renew your student membership.**

## 4. processing

❑ Standard Processing
NO EXTRA CHARGE
Please allow 7-10 days for receipt*

❑ One-Day Fax Service $15
Get your proof of insurance faxed to you within 24 hours of our receipt of your application.*
Your fax number is required.
( ) _____
_____

❑ Three-Day Priority Mail Service
$15(U.S. only)
Get all your materials within 3 business days of our receipt of your application*

*** processing subject to application being complete**


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## 5. my payment method

DO NOT SEND CASH. A $25 charge will be assessed on all returned checks.
**All fees paid to ABMP are non-refundable once your application is accepted.**

| | |
|---|---|
| ***12 Months*** | *$ 65* |
| ***18 Months*** | *$ 95* |
| ***24 Months*** | *$ 125* |
| *Total* | *$ _____* |

My method of payment is: ❑ Check/Money Order
❑ VISA/MasterCard ❑ Discover ❑ AMEX

Cardholder's Signature Required _____
Cardholder's Name: _____
Area Code & Ph. # of Cardholder: _____
(required **only** if different from applicant)

**Should you elect to upgrade to a fully insured ABMP membership level within 60 days of graduation or licensure, your student level dues will be applied to the cost of the upgrade.**

Card Number (please print clearly)

Exp. Date ____ ____ / ____ ____
month year

## 6. please sign & date application

**SIGNATURE IS REQUIRED.** Faxed and/or computer scanned signatures are considered legal and binding.

I understand that membership fees paid by me to ABMP are non-refundable, are fully earned as of the first class date, and will not be pro-rated. I understand that the professional liability coverage provided as a benefit of ABMP Student Membership includes coverage for outside / off-premises activities as long as those activities have been approved by the school and are permitted under applicable state and local government regulations. I understand that the term of ABMP Student Membership coincides with the first and last days of class, not to exceed twelve (12) months and that this level of membership IS NOT available to individuals taking solely a continuing education course or seminar. I understand that ABMP members are required to maintain the highest standards of professional conduct and strictly adhere to the ABMP Code of Ethics. I have never been the subject of any incident, pending claim, suit or investigation, in connection with any sexual act, misconduct, molestation, and/or assault whatsoever. I understand that my membership certificate will notify me that I have been added as an individual Member with respect to the coverage and limits of the Master Policy and that the original Master Policy may be inspected at the offices of the Association or I may order a copy for a handling fee of $10. I understand that the coverage provided by my membership certificate is subject to all terms, conditions, and exclusions contained in the Master Policy. Language in the Master Policy is governing. I further understand that ABMP provides liability insurance to qualified members and that the Insurance Company will rely on the information I have provided in this application. My signature below verifies that I have completed the ABMP membership application accurately and honestly. I understand that failure to pay required dues and/or false statements made on the application or subsequent renewals shall void this application, terminate membership, and render my insurance coverage null and void.

X _____ _____
Signature Date

**THIS BOX FOR ABMP USE ONLY**

❑ Fax Return ❑ Priority

**ITEMS:** _____

_____

Member ID No. _____

Amount Paid: $ _____ Check No. _____ ❑ M/V/D/AE

AD ____/____/____ ED ____/____/____

Clerk: _____ Date: ____/____/____

Verification: _____ Contact: _____

_____

Auth. NO. _____ REF NO. _____