Assistive Technology Mentors Association Membership Application

Full Accredited Member and Partial Accredited Member

(Attach additional pages as necessary)

- Both Full and Partial Accredited Member applicants must complete both the membership application and practising details forms

(Please type or print clearly. Incomplete applications will not be processed.)

Name of Applicant:

Family Name: ……

Given Name/s: …….. Title: …… (Mr, Mrs, Ms, Miss, etc.)

Job Title: ……

Business Name: ……

ABN:: ……..

Business Postal:

Address: ……

Suburb/City: …… State: …… Postcode: …….

Business Address:
(if different from above) ……

Suburb/City: ……..… State: …… Postcode: ……..

Home Address: ……

Suburb/City: …… State: …… Postcode: ……..

Country: ……

Phone/Email:

Business: …….. Fax: ……

Home: …….. Mobile: ……

Email: ……

Website: ……

Membership

Applying For: Full Accredited Member: ☐ Partial Accredited Member: ☐

(Note: Individuals applying for: Full Accredited Membership must have successfully completed the Cert IV in Assistive Technology Mentoring. Partial Accredited Members must have successfully completed one (1) or more unit/s of competency/s in the Cert IV in Assistive Technology Mentoring)

Proposer:

Name: ……..……

Email: ……... Phone ……..

(Note: Proposer must be full or partial accredited members of Assistive Technology Mentors Association and have agreed to propose this application)

Provide a brief statement detailing why you want to be a member of ATMA and what your interest in Assistive Technology is: *(Attach additional pages if necessary)*

ATMA Directory:

If you **DO NOT** want your details to be made publically available on the ATMA Members Directory/website, please tick:

Accredited Member Directory: ☐

Invoice for fees will be sent out if the application is approved:

Membership Fees:

(Tick appropriate membership)

Full Accredited Member: $250.00/year ☐ Partial Accredited Member: $75.00+/year ☐

(Minimum of 1 Cert IV units to be completed)

Annual membership period is from July to June each year (Australian financial year)

First year members: are invoiced pro rata according to the month of membership approval.

Partial Accredited Members: Must have completed at least one (1) Cert IV units of competency, calculated at $15.00/unit ($75.00). Invoice will be calculated at $15.00/unit for the number of Cert IV units of competency completed.

Declaration: _____ (print name)

I, hereby apply for membership of the Assistive Technology Mentors Association, and agree to abide by its rules, policies and code of conduct (if accepted as a member).
I certify that the information submitted in this application is accurate and true.

Signature of Applicant: _____ Date: ____/____/____

Please send completed membership application to:
Assistive Technology Mentors Association (ATMA)
PO Box 8034 WestPoint Blacktown NSW 2148 or email to: atma@at-aust.org

Practicing Details

(Attach additional pages as necessary)

A BRIEF DESCRIPTION OF YOUR BUSINESS/PRACTICE:

_____

_____

PROFESSIONAL REGISTRATIONS: (Registration to other organisations/bodies)

_____

_____

ACADEMIC ACHIEVEMENTS: (Course/s, Institution/s, Duration, Date completed)

_____

_____

ASSOCIATION MEMBERSHIPS: (Membership to other professional associations/bodies)

_____

_____

As an applicant for Fully/Partial Accredited Membership, I declare that the following is up-to-date and current:
Note: Individuals must work within the regulations of the country they are practising in).

PROFESSIONAL INDEMNITY INSURANCE:
(I have the required level of Professional Indemnity Insurance appropriate to the scope of work undertaken)

□ YES □ NO

NATIONAL WORKING WITH CHILDREN CHECK:

□ YES □ NO

NATIONAL POLICE CHECK:

□ YES □ NO

LOCATION/S PRACTICING:
(More than one (1) can be ticked)

□ ACT □ NSW □ NT □ QLD □ SA □ TAS □ VIC □ WA
□ OTHER COUNTRY: _____
Please specify

FUNCTIONAL AREAS PROVIDED:
(More than one (1) can be ticked)

□ Aged Care
□ Intellectual Disability
□ Speech Impairment
□ Other: *(please specify)* _____
□Cognitive Impairment
□ Physical Disability
□ Vision Impairment
□ Hearing Impairment
□ Psychological Disability

SERVICES OFFERED:

□ Built Environment
□ Communication
□ Daily Living
□ Digital Smart Technology
□ Hearing
□ Leisure/Recreation
□ Lifting/Transferring
□ Manual Wheelchairs
□ Memory Loss
□ Powered Mobility
□ Pressure Support
□ Transport
□ Vision
□ Walking Mobility
□ Peer Support Services
□ Other: *(please specify)* _____

REGISTERED NDIS PROVIDER:

(Within Australia)

□ YES □ NO

APPOINTMENT/MEETING TYPES OFFERED:

In Person/Face to Face
(at the same location)
□ YES □ NO

Virtual/Online:
□ YES □ NO

REFERENCES: *(Name, Address, & Contact Details for at least 2 referees)*

Referee 1:

Name: ……..

Address: ……..

Suburb/City: …… State: ……..… Country: ……

Post/Zipcode: ……

Business Phone: …… Mobile Phone: …….

Email: ……..

Referee 2:

Name: ……..

Address: ……..

Suburb/City: …… State:…….. Country: ……

Post/Zipcode: ……

Business Phone: …… Mobile Phone: …….

Email: ……..

OFFICE USE ONLY

Membership Type: ☐ Full ☐ Partial

Membership Approved: ☐ Yes ☐ No Date: ……/……/……

Approved by: ……..