



Associated Bodywork & Massage Professionals Student Membership Application

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Evergreen, CO 80437
ABMP.com
expectmore@abmp.com
p: 800-458-2267 f: 800-667-8260

personal information

Legal Name _____
(First) (Last)

Address _____

City _____

State _____ Zip _____

Home Phone () _____

Cell Phone () _____

Date of Birth ____ / ____ / ____ Gender M F
month day year

Email _____

(Email address is only used for membership and benefits notifications.)

training

School Name _____

City _____

State _____ Zip _____

Phone () _____

My program includes training for hot stone massage/therapies.
 Yes No

Length of Course _____ hours

Start Date ____ / ____ / ____

Expected Graduation Date ____ / ____ / ____

ABMP student membership liability insurance provides coverage only while you are enrolled in school. The insurance does not cover you if you practice for compensation, or when you have completed your training.

Referral Credit School/ABMP member ID # _____

Credit given to student's school upon student upgrade to a Certified, Professional, or Practitioner level of membership.

On occasion, ABMP rents its mailing list to qualified vendors who are interested in promoting their products and services to members. If you do not wish to receive these offers, please check here.

THIS BOX FOR ABMP USE ONLY Member ID No. _____

membership

Student Membership

Up to 12 months in school or until completion of training, whichever comes first. \$ 45

Membership is renewable, provided you remain in school and are not practicing for compensation. The Student insurance does not cover you if you practice for compensation, or after you have completed your training.

payment

Processing *(subject to application being complete)*

After your membership is processed, your certificate of insurance will be available online in your www.abmp.com account and you will have access to exclusive member benefits. **Please provide your email address so we can email you confirmation that your application has been processed.**

You'll also receive a membership packet by mail.

TOTAL \$ 45

Do not remit payment in cash. Returned checks subject to \$25 fee.

Check/Money Order Visa MC AmEx Discover

Cardholder's Name _____

Signature _____

Phone _____
only required if different from applicant

Card Number _____ Exp. ____ / ____

ABMP Student members are eligible for a special first-year rate after completion of training—\$150 for Practitioner or Professional membership, \$180 for Certified membership.

agreement

Your signature is required. Faxed, computer scanned signatures, and/or electronic acknowledgements are considered legal and binding.

I understand that membership fees paid by me to ABMP are nonrefundable, nontransferable, and will not be prorated.

I have completed the ABMP membership application honestly and accurately. I understand that ABMP members are required to maintain the highest standards of professional conduct and strictly adhere to the ABMP Code of Ethics. As a condition for my membership in ABMP and for receiving insurance coverage, I represent and warrant that (1) no malpractice or negligence allegation has ever been asserted against me, nor has there ever been any event or indication suggesting a claim may be made or that my care caused harm; (2) I have never been convicted of any violation of law other than a minor traffic offense; (3) no agency or association has investigated or taken any other action against me or my license. I understand that the insurance coverage provided to me through my ABMP membership is subject to all terms, conditions, and exclusions contained in the insurance policy, the language of which is completely controlling as to all matters relating to my coverage. I further understand that the insurance companies providing me such insurance coverage will rely on the information that I have provided in this application. Failure to pay any dues/premiums and/or false statements or representations made in this application or subsequent communications shall void this application, terminate membership, and render my insurance coverage void.

X _____

Signature required

Date