ASSOCIATION OF HEARING INSTRUMENT PRACTITIONERS OF ONTARIO

Membership Application 2023

AHIP will not consider an incomplete application

FULL MEMBER (New or First Time Full Member Only Fill Out Form) **$750.00**

1. This application must be accompanied by a valid Certificate of Insurance for Professional Liability for a minimum of $2,000,000.
2. First time members must also provide a proof of graduation (diploma) when applying for membership.
3. If applying for membership part-way through calendar year, please contact the AHIP office for pro-rated membership amount.

Payment: Cheque_____ MC/Visa/Amex______________________________Exp_ CVV code___
Credit Card only (not credit debit card)

A. APPLICANT INFORMATION **PLEASE PRINT CLEARLY**

LAST NAME FIRST NAME MIDDLE NAME

NAME AS YOU WISH IT TO APPEAR ON YOUR CERTIFICATE

COMPLETE HOME ADDRESS (Incl. Postal Code)

HOME or CELL PHONE # WORK PHONE # DATE OF BIRTH (DD/MM/YYYY)

EMPLOYMENT FULL & COMPLETE NAME, ADDRESS, CITY (incl. Postal Code)

MEMBER CONTACT PERSONAL EMAIL ADDRESS*(mandatory)*** (not work email)**

ARE YOU OR YOUR EMPLOYER CURRENTLY AN ASSISTIVE DEVICES PROGRAM VENDOR? ☐ YES ☐ NO

B. EDUCATION

PLEASE INDICATE ANY COLLEGE OR UNIVERSITY EDUCATION AQUIRED OR ATTENDING AT PRESENT.

NAME OF INSTITUTE	**PROVINCE (LOCATION)**	**YEARS COMPLETED**	**DEGREE**	**MAJOR SUBJECTS**	**COMPLETION DATE**

C. EMPLOYMENT

BEGIN WITH YOUR PRESENT PLACE OF EMPLOYMENT. LIST **EVERY** POSITION HELD FOR THE PAST 5 YEARS

NAME & COMPLETE ADDRESS OF EMPLOYER	DATES OF EMPLOYEMENT	DUTIES	FULL PART TIME	NAME & TITLE OF SUPERVISOR	REASON FOR LEAVING

D. QUALIFICATIONS

Length of experience actively and principally engaged in the practice of the testing of hearing and the selection, and or fitting and dispensing of hearing instruments.

___________________ ___________________
YEARS MONTHS

E. REFERENCES

BUSINESS REFERENCES:

1. COMPANY____

ADDRESS____

PHONE ____

2. COMPANY____

ADDRESS____

PHONE ____

PROFESSIONAL REFERENCES:

1. COMPANY____

ADDRESS____

PHONE ____

APPLICANT'S AFFIDAVIT

I hereby make application for membership in the Association of Hearing Instrument Practitioners of Ontario, and if accepted, I will abide by the By-Laws, Policies and Code of Ethics as established by the Association. I understand that failure to do this may be cause for cancellation and recall of my Certificate and expulsion from the Association. I further understand that continuance of my Membership is conditional upon my meeting the requirements for annual renewal of my Certificate.
I acknowledge that the Certificate of Membership is the property of the Association and that it will be returned upon demand by the Association.

____ ______________________

SIGNATURE **DATE**

PLEASE MAIL OR FAX COMPLETED APPLICATION FORM TO:
ASSOCIATION OF HEARING INSTRUMENT PACTITIONERS OF ONTARIO
55 MARY STREET WEST, SUITE # 211
LINDSAY, ONTARIO, K9V 5Z6
FAX 705 878-4110 or 1-844-688-5583

PLEASE INCLUDE PROOF OF GRADUATION (CERTIFICATE) AND PAYMENT OF YOUR MEMBERSHIP DUES AND PROOF OF $2,000,000 PROFESSIONAL LIABITY INSURANCE.
PROCESSING YOUR APPLICATION MAY TAKE UP TO 2-3 WEEKS. WHEN YOUR APPLICATION IS APPROVED, YOU WILL RECEIVE OFFICIAL NOTIFICATION BY MAIL FROM AHIP.

AHIP WILL NOT CONSIDER ANY APPLICATIONS THAT ARE NOT COMPLETE.

THIS SECTION FOR OFFICE USE ONLY- DO NOT WRITE IN THE SPACE BELOW

DATE RECEIVED: ______________________________ **APPROVED BY:** ______________________________

APPROVAL DATE: ______________________________ **MEMBERSHIP #:** ______________________________