College of Mental Health Pharmacy

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Application Form for Associate Membership of the CMHP

1. Personal Details

Surname | First Name | Title

2. Academic History

Qualification	Date of Attainment

3. Employment Details

Job Title | Grade

Date Started

Work Address:

Telephone Number:

Email Address:

Contact/Mailing Address if different from above:

Areas of Employment	Special Interests
○ NHS Mental Health Trust ○ Private Psychiatric Hospital ○ NHS General/Acute Hospital with mental health beds ○ Commercial Pharmacy Provider ○ Learning Disabilities ○ Community Services ○ PCT / SHA /CCG ○ Industry ○ Consultancy ○ Academia ○ Community pharmacy ○ Other (please state)	○ General Adult Psychiatry ○ Older Adult Psychiatry ○ Forensic Psychiatry ○ Mother & Baby ○ Learning Disabilities ○ CAMHS ○ Substance Misuse ○ Eating Disorders ○ Medicines Information ○ Pharmacy Management ○ Other (please state)

Payment Details

The joining fee is £30, which includes the first year's retention fee of £25. This is repayable if membership lapses beyond the second year. An annual retention fee of £25 is then payable on the 1st April each year. Membership fees are reviewed annually and are approved at the AGM.

Payment Method

Please indicate your method of payment accompanying your application and your preferred method of payment for annual renewal:

	Cheque	Standing Order	Credit / Debit Card	Bank Transfer
Joining Fee and First Year Subscription				
Annual Renewal				

Payment by Card:

Card Type															
Cardholder Name															
Card No.															
Start Date					Expiry Date					Security No.					
Issue No.															

Payment by Bank Transfer:

Sort Code: 40-35-34
Account No: 92722348

For international bank transfers
Swift / BIC Code: MIDLGB22
IBAN: GB07MIDL40353492722348

I, the undersigned, wish to apply for Associate Membership of the College of Mental Health Pharmacy. In doing so, I agree to the personal information detailed above, which to the best of my knowledge is a true and accurate representation of fact, being held on the current membership database. I understand that this information is private and confidential and will only be released by express permission of, and through, the authorised committee in accordance with the Data Protection Act. I authorise the CMHP to collect payment for annual renewal of membership fees unless cancelled in writing by me, in which event membership will cease at the end of the respective financial year.

Signature		Date	

Please send this completed application and payment (cheques payable to "CMHP") to:

College of Mental Health Pharmacy
The Axis Building, Maingate
Kingsway North, Team Valley
Gateshead
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🖷+44(0) 191 4046801