CANCER COUNSELLING PROFESSIONALS Inc

Easing the emotional burden of Cancer

Application for membership

Name: _____

Address: _____

_____

_____

Telephone contact: _____

E-mail: _____

Counselling qualifications: _____

_____

Year obtained: _____

On average how many hours of counselling do you provide per month?

_____

Where do you practise?_____

_____

_____

Of which professional association(s) are you a member?

_____

Please provide details of the category of membership(s) and your membership number(s)

_____

Please provide your company name and ABN *(required for private practitioners wishing to register for the Cancer Council counselling program)*

Applicant Name: ……..

With which company is your professional indemnity insurance*? (please provide a photocopy of your certificate)*

What experience of working with people affected by cancer do you have? Please provide full details

_____

_____

_____

What type(s) of counselling do you offer? Please answer in 35 words or less; this will be the basis of your website entry.

_____

_____

_____

_____

What modalities do you offer? (Face to face, phone, home visits etc)

_____

_____

Do you wish to be registered with the Cancer Council Counselling Program? Yes / No

Reasons for choice _____

_____

Members of the committee will process your form and you will receive further information from us shortly. It would be appreciated if you could email your application form to us to facilitate ease of distribution to other members of the executive for consideration.

Please return form and a copy of your:

- **Professional Indemnity Insurance**
- **Professional Association certificate**

Attention: The President
Cancer Counselling Professionals Inc
PO Box N652
Grosvenor Place
NSW 1220