GHANA ALTERNATIVE MEDICAL PRACTITIONERS ASSOCIATIONS (GAMPA)

*Attached Photo Here

Membership-Certification Application Form

Please complete this form accurately and attach all relevant documents. Incomplete applications will not be processed. All information provided will be treated with strict confidentiality.

Name of Mother Association: _____

Mother Association Approval: _____

New Application: _____

Renewal: _____

Student Application:_____

Section A: Personal Information

Full Name: _____

Date of Birth: _____

Gender: _____ Nationality: _____

Foreign Nationals: attach work permit

Contact Number: _____

Email Address: _____

Residential Address: _____

_____

Section B: Professional Information

Type of Practice (e.g., Naturopathy, Homeopathy, Chiropractic, Acupuncture, Integrative Medicine, Functional Medicine, Holistic Medicine, Ayurveda, Food supplement distributor, Massage and Manual Therapy (Reflexology, etc), etc):

_____

Years of Experience in Practice: _____

Practice Location(s): _____

Name of Facility:_____

Section C: Academic and Professional Qualifications

Highest Level of Qualification in CAM (Certificate/Diploma/HND/Degree/Masters/PhD):

_____

Other qualification(s) outside
CAM_____

Name of Institution(s): _____

_____

Year of Graduation: _____

Location:_____

Attach a copy of your qualification certificate(s).

Section D: Board/Licensure Examination

Have you taken the Board/Professional Licensure Examination? (Yes / No)

If yes, provide the following details:

- Year Taken: _____

  - Name of Examination_____

- Examination Center: _____

- Result (Pass / Fail): _____

Attach a copy of your result slip or certificate.

Section E:

SCREENING QUESTIONS – Applicants MUST answer all of the following questions.

Have you ever had any license, certification or registration denied, revoked or suspended?☐ YES
☐ NO

I f Y e s , typed explanation on a separate sheet of paper to this form)

A.	Have you ever been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	☐ Yes ☐ NO
B.	Have you ever been accused of practicing medicine without a license?	☐ Yes ☐ NO
C.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	☐ Yes ☐ NO
D.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	☐ Yes ☐ NO

All applicants must complete ALL questions. **If you answer "Yes" to any of the questions A through D, please provide a complete explanation on a separate sheet of paper and attach with this application form.**

Section F: Declaration

I hereby declare that the information provided in this application is true and correct to the best of my knowledge. I understand that any false information may result in disqualification or revocation of my membership if already granted.
Signature of Applicant: _____

Date: _____

Attached one recent passport-type photo of the applicant's face (approx. 2"X2") with applicant's name on the back, the photo must be original photo and cannot be computer-generated copy or paper copy. Quality of photo provided will be reflected on your certification certificate. OR email your photo in jpg *

For Official Use Only

Application Received By: _____

Date Received: _____

Documents Verified: _____

Membership Approved: (Yes / No)

Membership ID Assigned: _____

Signature of Approving Officer: _____

Date: _____