

Associate Subsidiary Membership Application

HPL 501c3 Institute
PO Box 564, Douglassville, PA 19518
484-332-3331
www.HPL501c3.org

Mr / Ms / Dr / Sifu / Etc. **First name** **Middle** **Lastname** _____ **Jr or Sr** _____ **Professional Certification (s)**

Company or DBA name

Street Address and/or PO Box number

City **State or Province** **Postal Code** **Country**

Home Phone

Cell Phone

Email Address

Membership Levels

- Practitioner Member .. \$180 per year/\$20 per month**
Practitioner Members gain the ability to log in, publicize events, & apply for certification.
- Professional Member ...\$295 per year/\$30 per month**
Professional Members gain the same benefits as Practitioner, but are also covered by HPL 501c3 Institute liability insurance.

Enclosed is payment in the amount of \$ _____

Check Credit Card Money Order Cash

Account # _____

.....Circle one: **MasterCard** **Visa**

Expiration Date _____

Code Number (3 or 4 digit number on the back of the card) _____

Signature: _____ Date: _____

Pledge of Ethical Behavior

As a practitioner or professional member of HPL Institute, I pledge to..

1. Always work for the benefit of the clients, patients, students, and colleagues with whom I work.
2. Honestly represent my Tai Chi (Taijiquan) and/or Qigong (Chi Kung) or other Integrative Health practices, education, and background. Make only factual statements about my abilities.
3. Act always with integrity. Be truthful in advertising.
4. Establish clear boundaries in all relationships with students, and/or clients and avoid inappropriate relationships at all times. Prevent harassment, abuse, or exploitation of students, clients and/or patients in my own practice, and if I see such behavior elsewhere.
5. Maintain confidentiality of any private communication regarding the health and progress of my clients/patients/students unless given express permission.
6. Explain financial arrangements in a clear and understandable manner.

Signature & Date

Professional applicants only

Please enter a 125 word maximum description of your service(s.)

Do you wish to be publicized in our Integrative Healthcare Practitioner Database? No Yes

- A. Are you currently under investigation or had any licensure board or professional association ever disciplined you? No Yes
- B. Have you ever had your hospital privileges, license, certification, or registration suspended or revoked by any licensure board, professional association or healthcare agency? No Yes
- C. Has your malpractice insurance ever been revoked? No Yes

If you answered *Yes* to any of these questions, please contact the office for further instructions.

Will you need a certificate of liability insurance for a third party additional insured? No Yes
If so, please enter name and address of additional insured:
