Society of Complementary Alternative and Holistic Practitioners

SCAHP

Membership-Certification Application

SECTION 1 TYPE OF CERTIFICATION

Check the box next to the certification for which you are applying.

☐ SCAHP Membership & Certification as ACAHP **$ 995.00**

☐ Duplicate Certificates (limit 5) ____ x $50.00 $_____.00

Total Enclosed $ .00

Make check or money order payable to SCAHP
A charge of $65.00 will be imposed for dishonored checks

MAIL TO:
Society of Complementary
Alternative and Holistic Practitioners
P O Box 96273
Las Vegas, NV 89193

OFFICE USE		
Check $	Check #	Staff
$_____.00		

NAME (Please Print Clearly or Type)

_____

SECTION 2 HOME ADDRESS and CURRENT E-MAIL ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐FLOOR ☐ PO BOX NUMBER_____

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE

HOME PHONE NUMBER E-MAIL ADDRESS

SECTION 2B BUSINESS ADDRESS and CURRENT BUSINESS INFORMATION

Please note: This information will be made available to the public unless otherwise requested.

COMPANY NAME

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐FLOOR ☐ PO BOX NUMBER_____

BUSINESS ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER BUSINESS E-MAIL ADDRESS

SECTION 2C PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future registration documents will be mailed. ☐ HOME ☐ BUSINESS

SECTION 3 LICENSES, CERTIFICATION, EDUCATION IN OTHER STATES/JURISDICTIONS

List all education or certifications or licenses earned

School, License or Certification Name City, State, Country	Number of Hours Completed	Date	Type* D/Certification/License

*** TYPE DESCRIPTIONS**

A. Educational degrees earned include type of degree **B.** Certifications **C**. License
D. Other (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 4 SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package, emailed or requested to be sent to the SCAHP. Keep a photocopy of all supporting documents for your records.

A.	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 *	Include ☐	Email ☐
B.	Signed SCAHP Practice Statement.	YES ☐	NO ☐
C.	Copies of legal documents supporting Education, Licenses, and Certifications submitted	YES ☐	NO ☐
D.	Check or Money Order for payment	YES ☐	NO ☐

SECTION 5 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 (If so attach a 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 6 SCAHP PRACTICE STATEMENT

I have read, understand, and agree to abide by these statements:

(initial each line)

___ The Code of Ethics for Complementary Holistic Practitioners (available on website–www.schap.org)

___ I am aware of the state laws where I plan to practice and understand laws vary from one state to another.

___ CAHP's educate consumers, helping them live happier healthier lives.

___ Never falsely lead any person to believe you practice anything other than complementary alternative holistic healthcare.

___ Providers may counsel individuals on the use of naturally occurring substances and the use of natural, non-invasive therapies.

___ Never instruct a client to discontinue any medications prescribed by any doctor.

___ Complementary Alternative Holistic Practitioners providers do not take x-rays, inject any substance by needle, remove blood by needle, perform any surgical procedures, or deliver infants without additional education in these professions.

Signature: _____ Print Name:_____ Date:_____

Please complete the affidavit of application below.

All applications that are unsigned by the applicant will be returned unprocessed.

SECTION 7 LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, are true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by the revocation of SCAHP membership and certification.

_____

NAME (Please Print Clearly or Type)

_____

APPLICANT SIGNATURE DATE

*Attached Photo Here