Fédération québécoise des massothérapeutes agréés
DEPUIS 1979

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APPLICATION FORM

FQM registration

Personal and strictly confidential information

Last name: _____ Date of birth: _____

First name: _____ Tel. (home) : _____

Address: _____ App: _____ Tel. (cell) : _____

City: _____ Fax: _____

Postal code: _____ E-mail: _____

ACADEMIC TRAINING			
SCHOOL, COLLEGE OR UNIVERSITY	PROVINCE, COUNTRY	YEAR	DEGREE OR CREDITS
TRAINING IN MASSAGE THERAPY			
Name of the massage therapy school			
Studied technic			

I, the undersigned, declare that the information provided on this form and on the training form is accurate and to be used for establishing my eligibility for Federation membership. I understand this information will remain strictly confidential. I realize that a false or misleading statement could constitute grounds for refusal.

Are you a member of another professional association? Yes ☐ No ☐

If so, indicate its name _____

ATTENTION: ***During the file processing period, I undertake to refrain from using the name of the FQM, either verbally or in writing, for use in any form of publicity. Only when I receive my active membership card will I be authorized to identify myself as a member in good standing of the Federation.***

_____ _____

SIGNATURE OF CANDIDATE DATE

The Federation reserves the right to refuse or expel any candidate or member if there exists serious grounds for believing that such person could harm the reputation of the profession or the Federation.