



## NIGERIA UNION OF PRACTITIONERS OF COMPLEMENTARY AND ALTERNATIVE MEDICINE (NUPCAM)

APP00122

**CONFIDENTIAL**

### MEMBERSHIP APPLICATION FORM

Dear Sir/Madam,

I hereby apply to be admitted as a regular member of the Nigeria Union of Practitioners of Complementary and Alternative Medicine, (NUPCAM).

I am a qualified CAM Practitioner and my particulars are as follows:

1. Name: \_\_\_\_\_  
Surname                      Middle Name                      First Name

2. Gender: M\_\_\_ F \_\_\_\_\_      3. Age: \_\_\_\_\_      4. Date of Birth: \_\_\_\_\_  
DD/MM/YR

5. Nationality \_\_\_\_\_      6. Place of birth \_\_\_\_\_

7. State of Origin: \_\_\_\_\_      8. Town: \_\_\_\_\_

9: Telephone(s): \_\_\_\_\_

10. E-mail Address: \_\_\_\_\_

11. State of Practice: \_\_\_\_\_      12. Town of Practice: \_\_\_\_\_

13. Address of Practice: \_\_\_\_\_

14. Area of specialization in CAM: \_\_\_\_\_

15. Do you practice any other branch of Medicine? Yes/No: \_\_\_\_\_

16. If yes, state your additional branch of practice and number of years of such practice: \_\_\_\_\_

17. Do you have a qualification in your additional practice? Yes/No: \_\_\_\_\_

18. If yes, state the qualification(s): \_\_\_\_\_

19. Educational Qualifications (Names of Schools with dates of attendance):

a. Primary School: \_\_\_\_\_

\_\_\_\_\_

b. Secondary School /High School \_\_\_\_\_

c. College (If applicable) \_\_\_\_\_

d. Higher Institution (University/Polytechnic/Professional School): \_\_\_\_\_

e. Post Graduate Institution (If any) \_\_\_\_\_

20. Degrees, Diplomas and Certificates obtained with dates: \_\_\_\_\_

21. Are you registered with any Government body as a CAM Practitioner in Nigeria? Eg. MDCN, TCAM Council of Nigeria, Federal Ministry of Health?  
Yes/No: \_\_\_\_\_

21b. If yes, specify: \_\_\_\_\_

22. What is the name of your health institution, if you are self-employed?  
\_\_\_\_\_

23. If you are self-employed, is your health institution registered with the State Ministry of Health? Yes/No: \_\_\_\_\_

23b. If yes, date of registration: \_\_\_\_\_

24. Is your health institution registered with the Corporate Affairs Commission?  
Yes/No: \_\_\_\_\_

24b. If yes, date of registration: \_\_\_\_\_

25. Have you practiced CAM in any other country? Yes/No: \_\_\_\_\_

25b. If yes, Name of Country: \_\_\_\_\_

25c. From \_\_\_\_\_ to \_\_\_\_\_

25d. Name the city where you practiced: \_\_\_\_\_

25e. Were you a registered/Licensed practitioner? Yes/No: \_\_\_\_\_

25f: Or did you practice under another colleague or institution: Yes/No \_\_\_\_\_

25g: If yes, name of colleague/institution: \_\_\_\_\_

25h. Number of years of practice under colleague or institution: \_\_\_\_\_

26. Are you currently employed by any health institution in Nigeria? Yes/No: \_

26b. Name of Institution: \_\_\_\_\_

26c. Date of employment: \_\_\_\_\_

26d. Position in your current employment: \_\_\_\_\_

**27. PLEDGE OF CORRECT INFORMATION:**

I do hereby pledge that all the information contained in this application form are true and if discovered that any information is false, I should be expelled from the Union and my name should be struck out of the register of members.

**28. PLEDGE OF SPECIFICITY:**

I do hereby pledge that I shall practice complementary and Alternative Medicine only, and if I wish to practice Allopathic or Orthodox Medicine, I shall obtain a qualification in it.

**29. PLEDGE TO ABIDE BY CAM CODE OF ETHICS:**

I do hereby pledge if admitted as a member, to abide by the unions code of ethics and if I violate the code of ethics, I should be expelled from the Union after three written warnings.

**30. PLEDGE TO PAY MY MEMBERSHIP AND OTHER FEES:**

I do hereby pledge, if admitted as a member, to pay my membership and other fees without being reminded. And if I violate this pledge, my name should be struck out of the register of members after three written warnings.

Name: \_\_\_\_\_  
Surname Middle Name First Name

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of State Chairman: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of State Secretary: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICIAL USE**

Application Fee: N5,000      Paid/Not Paid

Membership Fee: N25,000      Paid/ Not Paid

ID Card Fee: N5,000      Paid/Not Paid

Constitution Fee: N5,000      Paid/ Not Paid

Date: \_\_\_\_\_

ADMITTED/NOT ADMITTED

If not admitted, reasons for rejection:

1. Not qualified
2. No documents to support claim of qualification.
3. False information

**Note:**

This document must be forwarded by the State Branch to the National Secretary for entry into the National Register of members.

Please, submit your application through the branch where your practice is located.

All enquires should be channeled to the National Secretary, and the State Chairman NUPCAM.

Email, [nupcam.info@gmail.com](mailto:nupcam.info@gmail.com)

Tel: 08063962266, 07030386181

**All payments should be made to:**

**NIG. UNION OF PRACTITIONERS OF COMPLEMENTARY AND ALTERNATIVE MEDICINE (NUPCAM)**

**FIRST BANK PLC**

**ACC. NO. 2041272675**