HONG KONG ASSOCIATION FOR INFANT MENTAL HEALTH LIMITED MEMBERSHIP APPLICATION		
Name (*Surname first*):	中文姓名:	
Title:	Gender: □ M □ F	Contact number:
Email address:		
Correspondence address:		

PROFESSIONAL BACKGROUND

Profession:

□ Psychologist □ Psychiatrist □ Paediatrician □ Family Physician □ Medical doctor □ Nurse

□ Occupational therapist □ Physiotherapist □ Speech Therapist □ Educator □ Childcare worker

□ Social Worker □ Others (please specify:___________________________________)

Organisation:	Years of working in the profession:
Professional degrees (with graduation year):	

PROFESSIONAL REFEREE AND MEMBERSHIP TYPE

Name of professional referee *(1. Referee is required for full membership application only; 2. Referee must be a full member of the HKAIMH):*	Referee’s contact number:

Types of membership:

□ Full member HKD $200 per year □ Affiliate member HKD $100 per year □ Life member HKD$2,000

SUPPORTING INFORMATION

(E.g. information on your professional background and experience in infant and early childhood mental health, which will help the Committee to make a decision on your application)

Signature of applicant:	Date:

* Please mail the completed form together with a crossed cheque made payable to “Hong Kong Association for Infant Mental Health Limited” to “Hong Kong Association for Infant Mental Health Limited, Room 2802, Admiralty Centre, Tower 1, 18 Harcourt Road, Hong Kong”, and mark “New Membership Application” on the envelope.