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| **PERSONAL INFORMATION** |

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| **Dr / Mr / Mrs / Ms / Miss / Mdm** | FULL NAME AS PER NRIC / PASSPORT |

 (Write name in **BLOCK** letters. Underline family name.)

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| --- | --- | --- | --- |
| **Email:** |  | **Contact No.:** |  |

|  |  |
| --- | --- |
| **Employer:** |  |

**Select your current Membership Category:**

|  |  |
| --- | --- |
| **SAC Member ID:** |  |

* Fellow Member
* Master Clinical Member
* Clinical Member (Registered Counsellor)
* Provisional Clinical Member

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| **IMPORTANT NOTE** |

Article 5.5.1 of the SAC Constitution:

* All registrants **must show evidence of professional indemnity coverage** when they apply for new registration or renew their registration with the SAC Register of Counsellors.
* Please attach a copy of the insurance certificate or redacted policy document.

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| **DECLARATION BY APPLICANT** |

In my application for exemption from the provisions of Article 5.5.1 of the SAC Constitution, I hereby declare that:

* I have my own professional indemnity insurance policy.
* My employer/organisation covers me for the professional indemnity insurance.

***I understand that in the event of the change of employer indicated above, this declaration shall cease to take effect, and it is my responsibility to inform SAC accordingly.***

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| **Signature** |  | **Date** |

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|  |  |  |
| **Name & Signature of Employer** | ***(Insert company stamp)*** | **Date** |

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| **For Official Use** |
| **Received by:** |  |
| **Date of receival:** |  |
| **Date of processing:** |  |
| **Remarks:** | Completed / Not Completed |