

Complementary   
 Therapy Network

Application to join the LJMC Complementary Therapy Network:

**1** General information:

Name: Mr/Mrs/Miss/Ms: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_ Postcode: \_\_\_\_\_

telephone: \_\_\_\_\_ fax: \_\_\_\_\_

mobile: \_\_\_\_\_ email: \_\_\_\_\_

**2** Therapies (please include past & present complementary therapy training):

Therapies	Qualification & dates	Professional Body Membership	Years in practice	Charges
<b>Acupuncture</b>				
<b>Alexander Technique</b>				
<b>Aromatherapy</b>				
<b>Spiritual Healing</b>				
<b>Reiki</b>				
<b>Massage</b> (please state type)				
<b>Relaxation</b>				
<b>Reflexology</b>				
<b>Other</b>				

**3** Are you covered by a professional insurance scheme?      yes     no

please tick ✓

Date due for renewal: \_\_\_\_\_

**4** Area(s) of work: (please tick ✓ and describe as appropriate)

home:  \_\_\_\_\_ hours \_\_\_\_\_     clinic: \_\_\_\_\_ hours \_\_\_\_\_

salon:  \_\_\_\_\_ hours \_\_\_\_\_     other: \_\_\_\_\_ hours \_\_\_\_\_

**5** Information about practice:

Do you offer?	Yes	No	No, but would consider	Not applicable
Hourly (i.e. full or equivalent) sessions only				
Short sessions: e.g. half an hour				
Part body massage				
Sliding scale of charges				
Home visits				
Free sessions				

**6** Do you have any healthcare experience?      yes     no

(if so please give brief details:)

\_\_\_\_\_

\_\_\_\_\_

**7** Do you work or have you worked with cancer patients?      yes     no

(if so please give brief details:)

\_\_\_\_\_

\_\_\_\_\_

**8** What benefits would you aim for when working with people affected by cancer?

\_\_\_\_\_

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**9** How would you modify your work with people affected by cancer?

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**10** Please describe any relevant experience / expertise, personal or otherwise, that you have of working with people affected by cancer:

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**11** What further training/information might you find helpful to prepare you for working with people affected by cancer?

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**12** We are considering whether we could offer 'no payment' home visits for patients in particular need. Would you be interested in helping from time to time?    yes     no

**13** Have you ever been dismissed from employment or removed from any professional body on the grounds of professional misconduct in the UK or abroad?    yes     no

**14** Finally, please feel free to add any other information that you consider to be relevant to this application that has not been covered by the above questions:

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A network list of therapists is available to patients and their families. The list will include the following information:

1. Name                      2. Town                      3. Tel No.                      4. Therapies offered / practised

Do you agree to this information about yourself being included?    yes     no

I confirm that, to my knowledge, I meet the criteria and wish to be included in the LJMC Complementary Network List:

Signed: \_\_\_\_\_

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

Thank you for taking the time to complete this form.  
Please return it to:

Cherry Mackie  
Complementary Therapy Co-ordinator  
Lynda Jackson Macmillan Centre (LJMC)  
Mount Vernon Hospital, Rickmansworth Road  
Northwood, Middlesex. HA6 2RN

**DATA PROTECTION**

Please print your professional information in the following boxes:

Full name:	Discipline	Work tel. number	Work address	Other comments

I give my permission for the above information to be held on a password protected database within the LJMC, and to be used for professional purposes only.

Please sign here: \_\_\_\_\_

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