Associated Skin Care Professionals

# **Insured** Student Membership Application

PO Box 1869, Evergreen, Colorado 80437
800-789-0411 • Fax 800-790-0299

## get connected

With your membership you will receive:

- ✦ ***Liability Insurance.*** Coverage for all school-related sanctioned activities.
- ✦ ***Skin Deep.*** Our bimonthly member magazine for news on the latest products, trends, legislation, techniques and tools, marketing and practice advice.
- ✦ **Web Resources**. From the Members section of www.ascpskincare.com, you can connect with archived issues of *Skin Deep*, create your own FREE website, get a head start on developing marketing materials you can use when you graduate, and network with other skin care students and professionals. Log in to the Members section using your ID number as your username and your last name as your password.
- ✦ **Student Resources.** Our quarterly newsletter, *Fine Lines*, designed for the needs and concerns of skin care students.

Student membership is valid for one full year OR until graduation, whichever comes first.

## *Information*

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: ( ) _____

Date of Birth: _____/_____/_____
month day year

E-mail: _____

Gender: ❑ M ❑ F

## *Training*

School Name: _____

School's ASCP ID Number: _____

City: _____

State: _____ Zip: _____

Phone: ( ) _____

Length of Course: _____ hours

Start Date: _____

Completion Date: _____

## *Referral*

School Name/ASCP ID # _____

Referral Credit will be awarded to a student's school when the ASCP Student member upgrades to the Certified or Skin Care Professional level of membership.

## *Processing & Payment*

| | |
|---|---|
| Membership Dues | $ 59.00 |
| Standard Processing—7-10 days. | no charge |
| Fax Processing-$15-proof of membership faxed within 24 hours of our receipt of your application. | $_____ |
| (_____)_____ | |
| Priority Mail—$15 (U.S. only) within 3 business days of our receipt of application. | $_____ |
| **TOTAL** | **$** _____ |

**Do not remit payment in cash. Returned checks are subject to $25 fee. All fees paid to ASCP are non-refundable once your application is accepted.**

❑ Check/Money Order ❑ Visa/Mastercard/Amex/Discover

Cardholder's Name _____

Signature _____

Phone: ( _____ ) _____

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| | | | | | | | | | | | | | | | |

credit card number

| | | | |
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| | | | |

expiration date

*Should you elect to upgrade to a fully insured ASCP membership level within sixty days of graduation or licensure, your student level dues will be applied to the cost of the upgrade.*

## *Agreement*

**Your signature is required.** Faxed, computer scanned signatures, and/or electronic acknowledgements are considered legal and binding.

I understand that membership fees paid by me to ASCP are nonrefundable, nontransferable, and will not be prorated.

I have completed the ASCP membership application honestly and accurately. I understand that ASCP members are required to maintain the highest standards of professional conduct and strictly adhere to the ASCP Code of Ethics. As a condition for my membership in ASCP and for receiving insurance coverage, I represent and warrant that (1) no malpractice or negligence allegation has ever been asserted against me, nor has there ever been any event or indication suggesting a claim may be made or that my care caused harm; (2) I have never been convicted of any violation of law other than a minor traffic offense; (3) no agency or association has investigated or taken any other action against me or my license. I understand that the insurance coverage provided to me through my ASCP membership is subject to all terms, conditions, and exclusions contained in the insurance policy, the language of which is completely controlling as to all matters relating to my coverage. I further understand that the insurance companies providing me such insurance coverage will rely on the information that I have provided in this application. Failure to pay any dues/premiums and/or false statements or representations made in this application or subsequent communications shall void this application, terminate membership, and render my insurance coverage void.

_____
Signature & Date

**FOR ASCP USE ONLY**

❑ Fax Return ❑ Priority ❑ E-mail

ID No._____

Paid: $_____ Check No. _____ ❑ M/V/D/AE

AD _____/_____/_____ ED _____/_____/_____