

Aesthetic Association Application Form

5000 Dufferin St., # 202, Toronto, ON M3H 5T5
 Tel: 1-877-482-4678, Fax: 416-736-0148
 membership@aesthetic-association.com
 www. aesthetic-association.com



Membership # **ON-LN** _____

Please mark up for YES:

GENERAL

First name _____ **Last name** _____ **Middle initial** _____
Year of birth 19____, **Gender** Male. Female. **PHONE:** (____) _____ - _____ **FAX :**(____) _____ - _____

ADDRESS: Street _____

City _____ **State/Province** _____ **Zip/Postal Code** _____ **Country** _____

E-MAIL ADDRESS: _____ **Website:** http://www. _____

COMPANY NAME: _____

SECONDARY PRACTICE ADDRESS: Street _____

City _____ **State/Province** _____ **Zip/Postal Code** _____ **Country** _____

I am (please check all that apply)

- | | |
|---|---|
| Salon/Spa/Clinic owner <input type="checkbox"/> | Employed <input type="checkbox"/> |
| Mobile specialist <input type="checkbox"/> | Self-employed <input type="checkbox"/> |
| Educator <input type="checkbox"/> | A salon owner who does not perform treatments... <input type="checkbox"/> |
| Home based salon <input type="checkbox"/> | A supplier/consultant to the industry <input type="checkbox"/> |
| | Other (specify): _____ |

QUALIFICATIONS

Name of college/school _____

Qualification and date _____ Copy of certificate attached Sending later

Name of college/school _____

Qualification and date _____ Copy of certificate attached Sending later

Treatments I perform

- | | | |
|--|---|---|
| <input type="checkbox"/> Acne Treatments
<input type="checkbox"/> Aromatherapy
<input type="checkbox"/> Body Piercing
<input type="checkbox"/> Botox Injections
<input type="checkbox"/> Chemical Peels
<input type="checkbox"/> Cosmetic Injectables
<input type="checkbox"/> Cosmetic Tattooing
<input type="checkbox"/> Day Spa Treatments
<input type="checkbox"/> Detox Treatment
<input type="checkbox"/> Ear Piercing
<input type="checkbox"/> Electrolysis | <input type="checkbox"/> Evolence
<input type="checkbox"/> Facelift
<input type="checkbox"/> Facials
<input type="checkbox"/> Ipl/Photofacials
<input type="checkbox"/> Juvederm
<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Liposuction
<input type="checkbox"/> Manicure/Pedicure
<input type="checkbox"/> Massage
<input type="checkbox"/> Mesotherapy
<input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Nails
<input type="checkbox"/> Perlane
<input type="checkbox"/> Permanent Make Up
<input type="checkbox"/> Radiesse
<input type="checkbox"/> Restylane
<input type="checkbox"/> Tanning
<input type="checkbox"/> Threading
<input type="checkbox"/> Velashape
<input type="checkbox"/> Velasmoother
<input type="checkbox"/> Waxing
<input type="checkbox"/> Other |
|--|---|---|

APPLICANT'S SIGNATURE _____ DATE OF APPLICATION date / month / 20____

Additional Details: Referrals, Restrictions, Special Notices

MEMBERSHIP CATEGORIES (check one)

	Full year payment	Monthly withdrawals
BRONZE	<input type="checkbox"/> \$219.45 (1 month free)	<input type="checkbox"/> \$19.95
SILVER	<input type="checkbox"/> \$399.50(2 months free)	<input type="checkbox"/> \$39.95
GOLD	<input type="checkbox"/> \$899.95(3 months free)	<input type="checkbox"/> \$99.95

SIGN UP FOR the AUTO RENEWAL OPTION

- Yes, I want the convenience of automatic membership renewal. I authorize Aesthetic Association Inc. to renew my membership automatically on its anniversary date using the payment information and method I have specified below. Aesthetic Association will advise me in writing two months in advance of charges for the coming year. I can cancel this arrangement at any time by notifying Aesthetic Association in writing.
- No, I do not wish to automatically renew my annual membership.

FULL PAYMENT BY CHEQUE

Cheque is enclosed \$ _____ . _____

CREDIT CARD PAYMENT (You may use a VISA, Master Card, or American Express credit card.)

Credit Card No: _____ Expiration Date: month /20 year CVV2* _____

Name as it Appears on the Credit Card: _____

Address where you receive your credit card bill: (required by our bank for verification)

Street: _____ City/Town: _____

Province/State: _____ Country: _____ Postal Code/Zip: _____

Signature: _____ Date: date / month / 20 _____

*CVV2 is a 3-digit value at the end of your account number printed on the back of your credit card. On American Express cards, CVV2 number consists of 3-4 digits located on the front of the card

PRE-AUTHORIZED DEBIT PLAN (PAD) AGREEMENT

I/we authorize Aesthetic Association Inc., and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Aesthetic Associations membership. Regular monthly payments will be debited to my/our specified account on the 1st day of each month or the next business day.

This authority is to remain in effect until Aesthetic Association Inc. has received written notification from me/us of its change or termination. This notification must be received at least 20 (twenty) days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting cdnpay.ca. I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca

PLEASE PRINT CLEARLY

DATE: date / month /20_____

Name: _____

Street Address: _____

City/Town: _____ Province/State: _____ Postal Code/Zip: _____

Type of Service: Personal Business Telephone Number: _____

COMPLETE BANK ACCOUNT INFORMATION BELOW or ATTACH A VOID CHEQUE

Bank Name: _____

Financial Institution Number:

--	--	--	--

Branch Transit Number:

--	--	--	--	--	--

Deposit Account Number:

--	--	--	--	--	--	--	--	--	--

Branch Address : _____

Signature of Account Holder:

Signature of Joint Account Holder:

Name: _____

Name: _____

When the form is complete, mail or fax to: **Aesthetic Association Inc., 5000 Dufferin St., # 202, Toronto, ON M3H 5T5**
Tel: 1-877-482-4678, Fax: 416-736-0148 membership@aesthetic-association.com