

PART A:

- I am no longer practicing physiotherapy in NL and request that my name be removed from the register.
- I wish to change my Active registration to an Inactive registration or remain an Inactive registrant. I understand I shall not practice physiotherapy in NL as an Inactive registrant.

(Signature) (Date)

Surname _____ Given Names _____ Other / Maiden Name _____
Mailing Address _____
City / Town / Village _____ Province _____ Postal Code _____ Country _____
E-mail Address _____
Home Phone Number _____ Fax Number _____ Work Phone Number / Ext. _____

PART B:

- 1. Registration Number: _____
- 2. Citizenship Status: Canadian Citizen Landed Immigrant In Canada on a Work Permit
- 3. Gender: _____
- 4. Date of Birth (MM/DD/YYYY): _____
- 5. Place of Birth (Province, Country): _____

6. EDUCATION

Discipline/Degree:	Diploma	Baccalaureate	Master's	Doctorate	Grad Year:	University:	Country:
a) Physiotherapy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
b) Degree 1:	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
c) Degree 2:	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
d) Degree 3:	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

e) Specify the completion date(s) for the Physiotherapy Competency Examination (PCE):
Written: _____ Clinical: _____
 Exempt Please specify the reason for Exemption: Grandfathered AIT Accommodation

f) Please complete the following only if you have UNSUCCESSFULLY attempted the PCE:
 Written Date: _____ Clinical Date: _____

7. PREVIOUS JURISDICTION IN WHICH YOU WERE REGISTERED AS A PHYSIOTHERAPIST

- a) Registration Number: _____
- b) Province, Country: _____
- c) Regulatory Body: _____
- d) Period of Registration: _____

8. Canadian Physiotherapy Association (CPA)

- a) CPA Number: _____
- b) CPA Malpractice Insurance: Yes No
- c) Insurance Amount: _____
- d) Insurance Institution: _____

9. EMPLOYMENT

- a) Employment Status (CHOOSE ONLY ONE FROM 1 - 6):
 1. Employed in Physiotherapy
 2. Employed in Physiotherapy, On Leave
 3. Employed in Other than Physiotherapy and Seeking Employment in Physiotherapy
 4. Employed in Other than Physiotherapy and Not Seeking Employment in Physiotherapy
 5. Unemployed and Seeking Employment in Physiotherapy
 6. Unemployed and Not Seeking Employment in Physiotherapy
- b) Total Annual Hours Worked: (2015) _____ (2016) _____
- c) Total Other Hours: (2015) _____ (2016) _____
- d) Province you were first Employed in Physiotherapy: _____
- e) Year that you were first Employed in Physiotherapy: _____
- f) Official Canadian Language(s): English French
- g) Other Official Language(s): _____

PRIMARY EMPLOYER REPRESENTS WHITE BOXES, SECONDARY EMPLOYER REPRESENTS GREY BOXES

- h) Primary Employer: _____
- i) Secondary Employer: _____
- j) Employment Commencement Date: _____
- k) Employment Category (CHOOSE ONLY ONE WHITE AND ONE GREY):
 Permanent Temporary Casual Self-employed
- l) Full-time / Part-time Status (CHOOSE ONLY ONE WHITE AND ONE GREY):
 Full-time Part-time
- m) Employment Client Age Range (CHOOSE ONLY ONE WHITE AND ONE GREY):
 Paediatrics Adults Seniors All Ages
- n) Sector Status (CHOOSE ONLY ONE WHITE AND ONE GREY):
 Public Sector Private Sector (Includes self-employed)

PLEASE CHOOSE 1 WHITE AND ONE GREY BOX FROM EACH OF 10, 11 AND 12

WHITE = PRIMARY EMPLOYER, GREY = SECONDARY EMPLOYER

10. Place of Employment (Pick 1 white and 1 gray from 1 - 13)

- 1. General Hospital
- 2. Rehabilitation Hospital / Facility
- 3. Mental Health Hospital / Facility
- 4. Residential Care Facility
- 5. Assisted Living Residence
- 6. Community Health Centre
- 7. Visiting Agency / Business
- 8. Group Professional Practice / Clinic
- 9. Solo Professional Practice / Business
- 10. Post-secondary Educational Institution
- 11. School or School Board
- 12. Association / Government / Para-governmental
- 13. Industry, Manufacturing and Commercial

11. Clinical Focus on: (Pick one white and one gray from 1 - 5)

- 1. Musculoskeletal System
- 2. Neurological System
- 3. Cardiovascular and Respiratory System
- 4. Skin and Related Structures
- 5. More than One System

12. Area of Practice: (Pick one white and one gray from 1 - 27)

- 1. General Practice
- 2. Sports Medicine
- 3. Burns and Wound Management
- 4. Plastics
- 5. Amputations
- 6. Orthopaedics
- 7. Rheumatology
- 8. Vestibular Rehabilitation
- 9. Perineal
- 10. Oncology

- 11. Critical Care
- 12. Cardiology
- 13. Neurology
- 14. Respiriology
- 15. Health Promotion and Wellness
- 16. Palliative Care
- 17. Return to Work Rehabilitation
- 18. Ergonomics
- 19. Client Service Management
- 20. Consultant
- 21. Administrator
- 22. Teaching Physiotherapy related
- 23. Continuing Education
- 24. Other Education
- 25. Research
- 26. Sales
- 27. Other Area of Direct Service

Specify: _____

QUESTIONS 13 - 15 (CHECK THOSE APPLICABLE)

- Authorization for inclusion on Mailing List:
- 13. Survey: Home Work E-mail
 - 14. Educational: Home Work E-mail
 - 15. Product/Promo: Home Work E-mail

DECLARATION STATEMENT

I, _____, certify that to the best of my knowledge:

1. Neither my professional conduct nor my practice of physical therapy is under investigation in any jurisdiction;
2. I am not the subject of disciplinary proceedings, nor do I have restrictions on my license in any jurisdiction;
3. I have not been found guilty of any offense under any statute in Canada or abroad;
4. I have and will continue to hold CPA membership and professional liability insurance during the registration period stated herein;
5. The information provided on this form is true.
6. For renewing members only: I have maintained my professional portfolio according to the guidelines of the college.

(Signature) _____
(Date)