

**NEWFOUNDLAND AND LABRADOR COLLEGE OF PHYSIOTHERAPISTS**

P. O. BOX 21351  
ST. JOHN'S, NL CANADA A1A 5G6

Telephone: 709-753-6527 Fax: 709-753-6526  
E-mail: registration@nlcpt.com

**2019-2020 APPLICATION FOR REGISTRATION**

**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: _____			
		<input type="checkbox"/> Exempt		Please specify the reason for Exemption: <input type="checkbox"/> Grandfathered <input type="checkbox"/> AIT Accommodation			
f) Please complete the following only if you have UNSUCCESSFULLY attempted the PCE:		<input type="checkbox"/> Written		Date: _____		<input type="checkbox"/> 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: (2017) \_\_\_\_\_ (2018) \_\_\_\_\_
- c) Total Other Hours: (2017) \_\_\_\_\_ (2018) \_\_\_\_\_
- 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)