

NEWFOUNDLAND AND LABRADOR COLLEGE OF PHYSIOTHERAPISTS

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CLOSURE OF A CLINIC

Name of Clinic: _____

NLCP Registration Number: _____

Address of Clinic: _____

_____ ; **Postal Code:** _____

Forwarding Address: _____

_____ ; **Postal Code:** _____

Names of Contacts:

Date of Closure: _____

Who is Responsible for Client Records?:

Name: _____

Address: _____

Location of Clients' Records:

Signature(s) of Signing Officer(s):

_____ ;

_____ ;

Please complete and return to the Registrar at the address above.