

**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

**2022-2023 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: \_\_\_\_\_  
 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: (2020) \_\_\_\_\_ (2021) \_\_\_\_\_
- c) Total Other Hours: (2020) \_\_\_\_\_ (2021) \_\_\_\_\_
- 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 1 GREY BOX FROM SECTIONS 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 1 white and 1 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 1 white and 1 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)