



NEWFOUNDLAND AND LABRADOR COLLEGE OF PHYSIOTHERAPISTS

P.O. Box 21351 St. John's, Newfoundland and Labrador, CANADA A1A 5G6

Phone : 709-753-6527 Fax : 709-753-6526

E-mail: registration@nlcpt.com Website: <https://nlcpt.com>

RENEWAL OF REGISTRATION OF A PHYSIOTHERAPY CLINIC - July 1, 2024 - June 30, 2025

NLCP Clinic Registration Number: _____

1. NAME OF CLINIC: _____

Clinic Address: _____ Postal Code: _____

Mailing Address : _____ Postal Code: _____

Telephone: _____; (Fax) _____; E-mail: _____

2. TYPE OF BUSINESS: Is the business a: (Tick one)

___ Proprietorship? ___ Partnership? ___ Corporation? Incorporation Number: _____

Address of Registered Office: _____

_____ Postal Code: _____

(Enclose copy of current incorporation certificate)

3. CONTACT INFORMATION: Principle Contact:

Name: _____; Title: _____; Phone: _____

4. SHAREHOLDERS; (if a Partnership list OWNERS)

If a Partnership indicate percentage of Ownership in space for Number of Shares*.

NAME	ADDRESS	Number (%) of Shares:	Class of Shares:	Number of Votes:
------	---------	--------------------------	---------------------	---------------------

1. _____

2. _____

3. _____

Please enter names, addresses and other Shareholder information (including beneficial shareholders) on a separate page, if applicable.

5. DIRECTORS:

Name: _____ Residential Address: _____

1. _____

2. _____

3. _____

Please enter names, addresses and other Directors information on a separate page, if applicable.

6. OFFICERS:

Name: _____ Address: _____ Title: _____

1. _____

2. _____

3. _____

Please enter names, addresses and other Officers information on a separate page, if applicable.

7. PHYSIOTHERAPISTS ON STAFF:

Name: _____ **Registration Number:** _____ **Employee/Contract:** _____ **Full/Part Time:** _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Please enter other names and required information on a separate page, if applicable.

8. SUPPORT STAFF:

Name: _____ **Job Title:** _____ **Roles:** _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Please enter other names, job titles and roles on separate page, if applicable.

9. Is there an update to the shareholders' agreement in 2024-2025? Yes: _____ No: _____

10. Clinic Malpractice Insurance Carried: _____ **Amount:** _____
(Minimum required \$5,000,000)

Insurance Company: _____
(Please enclose a copy of your clinic's malpractice certificate.)

STATEMENT OF COMPLIANCE:

_____ (Clinic) acknowledges that its is in full compliance with the requirements of the College in respect of the registration of the Clinic under the Physiotherapy Act as a clinic authorized to provide physiotherapy services only through members of the College and that the Clinic is in full compliance with the College's Guidelines for Clinics.

The Clinic has in place an up to date set of standards and policies for the delivering physiotherapy services, including:

- 1. Standards of Practice for Physiotherapists;
- 2. Guidelines for Use of Support Personnel;
- 3. Guideline for the Retention and Transmission of Electronic Health Information for Physiotherapists
- 4. Policies and Procedures Manual with written policies on:
 - (i) Fee Schedules
 - (ii) Billing Practices
 - (iii) Cancellation Policies
 - (iv) Job Descriptions for Physiotherapists
 - (v) Equipment Calibration
 - (vi) Supervision Model
 - (vii) Record Keeping
 - (viii) Use of Support Personnel
 - (ix) Job Descriptions for Support Personnel
 - (x) Privacy of Client Health Information.

CLINIC: _____

Per: _____
(Name and officer of Clinic)

Per: _____
(Name and officer of Clinic)

Date: _____

Date: _____