



Please complete the entire form and return it, along with the fee and proof of malpractice insurance (if other than CPA), to the College office by 2400 hours, December 15th, 2009. Please make changes only where applicable. For clarification on any section of the form please refer to the Annual Registration Guide enclosed.

Section A: General Information

Information label goes here

Changes in Information only

Name: _____

Address: _____

Work Phone: _____

Home Phone: _____

Email: _____

Language Fluency: English French Other: _____

Practice Hours: Worked Hours 2009 _____
Professional Hours 2009 _____
Total Hours 2009 _____

Professional Registration:

If you are currently registered to practice physiotherapy in another jurisdiction, please indicate:

Province/State Country Registration/License #

Professional Conduct:

1) Have you had a finding of professional misconduct, incompetence, or incapacity against you in any jurisdiction in the past year? Yes No

2) Are you currently facing a procedure for professional misconduct, incompetence, incapacity, in any jurisdiction? Yes No

3) Have you been found guilty of a criminal offence or an offense related to the practice of physiotherapy in the past year? Yes No

If you answered yes, to any of the above please provide details:

ADDITIONAL INFORMATION

SECTION B: RENEWAL OPTIONS AND PAYMENTS

Renewal Options	Fee	Selection
General practicing/non practicing registration January 1 to December 31, 2010	\$380.00	<input type="checkbox"/>
General practicing/non-practicing registration January 1 to March 31, 2010 only!	\$190.00	<input type="checkbox"/>
Inactive / Retired	\$60.00	<input type="checkbox"/>
Resign from College	-	<input type="checkbox"/>

All renewals postmarked after Dec. 15th, 2009 will be processed only if they include the late fee of \$100.00 in addition to the registration fee.

PAYMENT OPTIONS:

Please indicate method of payment:

- Cash
- Cheque
- Mastercard
- Visa

If paying by credit card please provide information below:

Card# _____
 Card Verification Number _____
 Expiry date: _____
 Cardholder's Name: _____
 Signature: _____

Amount: _____

DECLARATION

RELEASE OF INFORMATION

I hereby allow my name and address to be released by the College office as indicated below:

- for College information only (by Email Mail)
- for educational opportunities
- for research related to physiotherapy

GENERAL

- I declare that all statements made on these forms are complete and accurate to the best of my knowledge and that I am not subject to any findings of misconduct, or criminal proceedings related to the practice of physiotherapy, in any jurisdiction.
- I understand that I must notify the College office in writing within 30 days of a change in name, address, or employment.
- I understand that providing false or misleading information is viewed by the College as professional misconduct.
- I understand that the College may verify any information reported on this form.

Signed: _____

Dated: _____

FOR OFFICE USE ONLY

Date Received _____ Complete Incomplete (Date sent back: _____)

Date Entered _____ Date Re-submitted _____

Section C: Current Employment Information

C1: Primary Employment

Employer Name: _____

Employment Site: _____

Address: _____

Employment Category: Employee Self-Employed

Employment Status: Permanent Full-time Permanent Part-time
 Temporary Full-time Temporary Part-time

Description of Place of Employment: (Choose one)

- | | |
|---|---|
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Other Visiting Agency |
| <input type="checkbox"/> Pediatric Hospital | <input type="checkbox"/> Industry |
| <input type="checkbox"/> Long Term Care Hospital/Facility | <input type="checkbox"/> School Board |
| <input type="checkbox"/> Facility for Mentally Challenged | <input type="checkbox"/> University/Educational Institution |
| <input type="checkbox"/> Psychiatric Facility | <input type="checkbox"/> Professional/Health Association |
| <input type="checkbox"/> Community Health Centre | <input type="checkbox"/> Consulting Firm /Agency |
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Government /Other Official Agency |
| <input type="checkbox"/> Home Care Program | <input type="checkbox"/> Other(specify)_____ |

Area of Responsibility: (Check those that apply as primary area(s) and indicate percentage of time spent.)

Direct patient care _____%	Teaching _____%
Administration _____%	Consultation _____%
Research _____%	Other (specify) _____%

Percentage must total 100

Area of Practice: (Check primary area(s) of clinical practice and indicate percentage of time spent.)

Respirology _____%	Mentally Challenged _____%
Cardiology _____%	Sports Medicine _____%
Orthopedics _____%	Gerontology _____%
Neurology _____%	Palliative Care _____%
Rheumatology _____%	Amputees _____%
Burns/Plastics _____%	General _____%
Ob/Gyn/prenatal _____%	Health Prevent/Promotion _____%
Psychiatry _____%	Other(specify) _____%

Percentage must total 100

Category of Patients:

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Pediatric | <input type="checkbox"/> Geriatric |
| <input type="checkbox"/> Adult | <input type="checkbox"/> All Ages |

Classification of Patients:

- | | |
|---|---|
| <input type="checkbox"/> Acute | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Mixed |

Dated: _____

This information is correct and complete to the best of my ability. Signed: _____

Section C: Current Employment Information

C2: Secondary Employment

Employer Name: _____

Employment Site: _____

Address: _____

Employment Category: Employee Self-Employed

Employment Status: Permanent Full-time Permanent Part-time
 Temporary Full-time Temporary Part-time

Description of Place of Employment: (Choose one)

- | | |
|---|---|
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Other Visiting Agency |
| <input type="checkbox"/> Pediatric Hospital | <input type="checkbox"/> Industry |
| <input type="checkbox"/> Long Term Care Hospital/Facility | <input type="checkbox"/> School Board |
| <input type="checkbox"/> Facility for Mentally Challenged | <input type="checkbox"/> University/Educational Institution |
| <input type="checkbox"/> Psychiatric Facility | <input type="checkbox"/> Professional/Health Association |
| <input type="checkbox"/> Community Health Centre | <input type="checkbox"/> Consulting Firm /Agency |
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Government /Other Official Agency |
| <input type="checkbox"/> Home Care Program | <input type="checkbox"/> Other(specify)_____ |

Area of Responsibility: (Check those that apply as primary area(s) and indicate percentage of time spent.)

Direct patient care	_____%	Teaching	_____%
Administration	_____%	Consultation	_____%
Research	_____%	Other (specify)_____	_____%

Percentage must total 100

Area of Practice: (Check primary area(s) of clinical practice and indicate percentage of time spent.)

Respirology	_____%	Mentally Challenged	_____%
Cardiology	_____%	Sports Medicine	_____%
Orthopedics	_____%	Gerontology	_____%
Neurology	_____%	Palliative Care	_____%
Rheumatology	_____%	Amputees	_____%
Burns/Plastics	_____%	General	_____%
Ob/Gyn/prenatal	_____%	Health Prevent/Promotion	_____%
Psychiatry	_____%	Other(specify) _____	_____%

Percentage must total 100

Category of Patients:

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Pediatric | <input type="checkbox"/> Geriatric |
| <input type="checkbox"/> Adult | <input type="checkbox"/> All Ages |

Classification of Patients:

- | | |
|---|---|
| <input type="checkbox"/> Acute | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Mixed |

Dated: _____

This information is correct and complete to the best of my ability. Signed: _____