COLLEGE & ASSOCIATION OF
Acupuncturists
OF ALBERTA

ALBERTA ACUPUNCTURIST REGISTRATION RENEWAL FORM

Please check the appropriate box that you are applying for:

☐ FULL ☐ TEMPORARY ☐ RESTRICTED ☐ INACTIVE

INSTRUCTIONS

Please provide all the information requested. You may attach another sheet if you need more space to answer any questions or explain any of your answers.

PERIOD OF RENEWAL: January 1 to December 31, 2017

Please provide the address that you wish available to the public on the acupuncture registry. Please note that all future correspondence will be forwarded to this address and/or to your email address listed.

TITLE (Ms./Mrs./Dr./Mr.)	SURNAME	FIRST NAME	MIDDLE INITIALS

PUBLIC MAILING ADDRESS:

CITY: **PROVINCE:** **POSTAL CODE:**

REGISTRATION #: R **BUSINESS PHONE #:**

FAX #: **RESIDENCE PHONE #:**

E-MAIL ADDRESS:

REPORTING PERIOD for Practice Experience/Professional Development

January 1 to December 31, 2016

Clinic Name of Practice during Reporting Period	Address of Place of Practice	Phone Number	From Month	To Month
1.				
2.				

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FOR THE PURPOSE OF DEMONSTRATING MAINTENANCE OF COMPETENCY

A. PLEASE INDICATE:

Reporting period January 1 to December 31, 2016	**TOTAL HOURS**
1) Total number of direct hours you practised acupuncture	
2) Total number of indirect hours (teaching, research, observation, professional services)	

Reporting period January 1 to December 31, 2015	**TOTAL HOURS**
1) Total number of direct hours you practised acupuncture	
2) Total number of indirect hours (teaching, research, observation, professional services)	

B. PLEASE use point form to BRIEFLY DESCRIBE the names of disorders or diseases treated during the reporting period (i.e., bronchitis, lung yang deficiency)

C. PLEASE INDICATE the approximate percentage of the following modes of therapy you used in your practice during the reporting period:

_____ classic (needle) acupuncture

_____ acupressure

_____ electro-acupuncture

_____ moxibustion

_____ cupping

_____ other (please specify - eg., auricular acupuncture/ hand acupuncture/laser acupuncture/scalp acupuncture

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D. PLEASE LIST THE NAMES OF ANY CONTINUING EDUCATION PROGRAM(S) YOU ATTENDED OR PARTICIPATED IN DURING THE REPORTING PERIOD. (For types of activities accepted, please visit our website at www.acupuncturealberta.ca) PLEASE ADD A SEPARATE SHEET IF MORE SPACE IS NEEDED.

Please list them in the order from most recent to most dated.

Name of Course/Seminar	Offered by (Agency and/or Instructor)	Total Number of Instructional Hours		Topic(s) Addressed
		Clinical	Theory	
1)				
2)				
3)				
4)				

IMPORTANT NOTES:

- Registration renewal fee for the year 2017 remains $660.00.
- Annual premium for $2M professional liability insurance coverage for the year 2017 is $164.00. If you choose to opt out, please provide proof of adequate insurance coverage.
- Regarding Commercial General Liability (CGL), premium for $2M coverage limit is $93.00, and for $3M coverage limit is $124.00.
- For existing members of the insurance program, no application form is required for renewal.
- Please include your **registration fee and premium payment** in one check, **payable to the CAAA**.
- To ensure continuity of your registration and insurance coverage, please submit your completed registration renewal form and payment by the deadline, **December 31, 2016** to the address below. **The CAAA is not responsible for cancellation of your insurance coverage due to your late payment.**
- Application for renewal of registration not received by December 31, 2016 may be subject to an additional fee of $25.00. Submission of incomplete forms may delay registration renewal.

COLLEGE AND ASSOCIATION OF ACUPUNCTURISTS OF ALBERTA
#201, 9612 – 51 Avenue NW
Edmonton, Alberta T6E 5A6

Please complete the following declaration:

I, THE UNDERSIGNED, ATTEST THAT ALL THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

REGISTRANT'S SIGNATURE: _____ DATE: _____

OFFICE USE ONLY

VERIFIED **ENTERED**