



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, 2019

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 <small>(Ms./Mrs./Mr./Dr)</small>	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, 2018				
Clinic Name of Practice during Reporting Period	Address of Place of Practice	Phone Number	From Month	To Month
1.				
2.				



FOR THE PURPOSE OF DEMONSTRATING MAINTENANCE OF COMPETENCY

A. PLEASE INDICATE:

Reporting period January 1 to December 31, 2018	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, 2017	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) |



D. PLEASE LIST THE NAMES OF ANY CONTINUING EDUCATION PROGRAM(S) YOU ATTENDED OR PARTICIPATED IN DURING THE REPORTING PERIOD. PLEASE USE THE ENCLOSED CEU REPORTING FORM FOR BETTER CLARITY.

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

IMPORTANT NOTES:

- Registration renewal fee for the year 2019 is \$760.00.
- Annual premium for \$2M professional liability insurance coverage for the year 2019 is \$168.00. 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, 2018** to the address below. **The CAAA is not responsible for cancellation of your insurance coverage due to your late payment.**
- Based on the stamp date on the envelope, applications for renewal of registration mailed after January 1, 2019 may be subject to an additional late fee of \$400.00. 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: _____

VERIFIED	OFFICE USE ONLY	ENTERED
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