



**LETTER OF STANDING**

If you have practised as an acupuncturist OR other type of regulated healthcare provider for any length of time in Alberta or another jurisdiction, you must request a Letter of Standing from those regulatory authorities. The completed Letter of Standing must be returned directly to the College of Acupuncturists of Alberta.

**SECTION 1: CONSENT TO RELEASE OF INFORMATION**

This section is to be completed by the applicant and sent to the regulatory authority for completion. Ensure to attach this form to the subsequent pages.

Applicant Full Name:	Practice Permit/License Number:
Mailing Address:	
Email:	Phone:

I, \_\_\_\_\_ (print name), authorize the regulatory authority named below to provide, at my expense if applicable, the information in Section 2 requested by the College of Acupuncturists of Alberta. I understand and accept this means the regulatory authority will provide full disclosure of any and all information determined by the regulatory authority to be relevant to my application for registration as an acupuncturist in Alberta.

Name of regulatory authority:	
Signature of applicant:	Date of signing:

**The rest of the document is to be completed by the regulatory authorities and returned directly to the College of Acupuncturists of Alberta.**



**SECTION 2: LETTER OF STANDING**

The information in this section is to be provided by the regulatory authority and returned directly to the mailing address below:

To: Registrar  
College of Acupuncturists of Alberta  
#201, 9612 – 51 Ave. NW  
Edmonton, AB T6E 5A6

**Registrant Information**

Name of Registrant:		Registration/License Number:
Date of Initial Registration:		Registration Designation (titles authorized):
Current Registration Status (Active; Suspended; Cancelled; Lapsed):		
<b>Registration Record (suspension, cancellation, lapses or breaks in registration, if applicable.)</b>		
Date	Status	Reason for change

**Professional Conduct Record**

Has the registrant ever been the subject of a complaint, inquiry or disciplinary proceeding respecting their practice, conduct, competence, incapacity or professionalism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the registrant ever had conditions/limitations imposed on their practice permit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, please provide details/documentation. Please attach additional pages if space below is insufficient.

**Continuing Competence**

Has the registrant ever failed to comply with your practice requirements (e.g. practice hours)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the registrant ever failed to comply with your continuing competence/education requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, please provide details/documentation. Please attach additional pages if needed.



**Other Relevant Information**

Please provide any other relevant information regarding the standing of the registrant with your organization.

**Regulatory Authority Information:**

Regulatory authority name:

Regulatory authority address:

Phone:

Email:

Date of issue:

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**Registrar's Signature**

**Please affix seal in space above.**