

APPLICATION FOR REGISTRATION AS AN ACUPUNCTURIST (REINSTATEMENT)

INSTRUCTIONS

If you have been non-practicing for a period of two (2) or more years or have had your practice permit cancelled, you must submit an application for registration as an acupuncturist in Alberta. Return to practice requirements are outlined in the [Return to Practice Policy](#).

Please note: This application is valid for three (3) months. If the Application is not completed within three (3) months, a new application and fee must be submitted. All completed applications must be sent via email in PDF format to registration@acupuncturealberta.ca. Do not send multiple emails.

PERSONAL INFORMATION (Provide copies of 2 pieces of identification)

LEGAL LAST NAME		LEGAL FIRST NAME	LEGAL MIDDLE NAME
REGISTRATION #	TITLE (MS./MRS./MR.)	GENDER	DATE OF BIRTH MM/DD/YYYY

1. MAILING ADDRESS

HOME ADDRESS		APT/SUITE/UNIT
CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS		PHONE NUMBER

2. PRIMARY CLINIC ADDRESS

CLINIC NAME	PLEASE BE ADVISED THAT ANY INFORMATION PROVIDED IN THIS SECTION WILL BE USED ON THE CAA PUBLIC REGISTRY	
CLINIC ADDRESS	APT/SUITE/UNIT	
CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS		PHONE NUMBER
PREFERRED MAILING ADDRESS (PLEASE SELECT ONLY ONE) <input type="checkbox"/> HOME ADDRESS <input type="checkbox"/> CLINIC ADDRESS		

3. EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME		RELATIONSHIP
EMERGENCY CONTACT ADDRESS		APT/SUITE/UNIT
CITY	PROVINCE	POSTAL CODE
EMAIL ADDRESS		PHONE NUMBER

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4. CITIZENSHIP

Are you a citizen or permanent resident of Canada?

- Yes** – enclose a clear photocopy of your Canadian passport, Canadian citizen card, birth certificate or Canadian permanent resident card
- No** – enclose a clear photocopy of your valid Canadian Government issued work permit

5. ACUPUNCTURE EDUCATION (Provide proof of education completion)

NAME OF PROGRAM		PROGRAM START DATE MM/DD/YYYY	GRADUATION DATE MM/DD/YYYY
NAME OF EDUCATIONAL INSTITUTION			TOTAL PROGRAM HOURS
ADDRESS			TOTAL CLINICAL HOURS
CITY	PROVINCE/STATE	COUNTRY	POSTAL CODE/ ZIP CODE

NAME OF PROGRAM		PROGRAM START DATE MM/DD/YYYY	GRADUATION DATE MM/DD/YYYY
NAME OF EDUCATIONAL INSTITUTION			TOTAL PROGRAM HOURS
ADDRESS			TOTAL CLINICAL HOURS
CITY	PROVINCE/STATE	COUNTRY	POSTAL CODE/ ZIP CODE

6. ADDITIONAL ACADEMIC INFORMATION (Attach degrees, diplomas and certifications if not previously submitted) Start from High School information to most recent. Attach another page if needed.

NAME OF PROGRAM		PROGRAM START DATE MM/DD/YYYY
NAME OF EDUCATIONAL INSTITUTION		GRADUATION DATE MM/DD/YYYY
ADDRESS		INSTRUCTION LANGUAGE
CITY	PROVINCE/STATE	COUNTRY
POSTAL CODE/ ZIP CODE		

NAME OF PROGRAM		PROGRAM START DATE MM/DD/YYYY
NAME OF EDUCATIONAL INSTITUTION		GRADUATION DATE MM/DD/YYYY
ADDRESS		INSTRUCTION LANGUAGE
CITY	PROVINCE/STATE	COUNTRY
POSTAL CODE/ ZIP CODE		

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7. REGISTRATION EXAMINATIONS		
<i>Applicants must provide information about passed Alberta Acupuncturist Registration Examinations or licensing examination as an acupuncturist in North America or elsewhere.</i>		PLEASE ENSURE ALL DOCUMENTATION IS ENCLOSED WITH APPLICATION FORM
NAME OF EXAMINATION	JURISDICTION	DATE OF EXAMINATION MM/DD/YYYY
NAME OF EXAMINATION	JURISDICTION	DATE OF EXAMINATION MM/DD/YYYY
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NAME OF EXAMINATION	JURISDICTION	DATE OF EXAMINATION MM/DD/YYYY

8. PRACTICE EXPERIENCE		
CAA Initial registration date _____ MM/DD/YYYY		
Last date of practice as an acupuncturist in Alberta _____ MM/DD/YYYY		
Return to practice start date _____ MM/DD/YYYY		
NOTE: NON-PRACTICING STATUS IS EFFECTIVE FOR A MAXIMUM OF TWO (2) YEARS		
During the FIVE years immediately preceding the date on which you submit this application,		
➤ Did you practise at any time as a self-employed acupuncturist?		<input type="checkbox"/> Yes <input type="checkbox"/> No
➤ Have you provided acupuncture services as a paid or unpaid employee, consultant, contractor or volunteer?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please complete the following:		
NAME OF CLINIC OR EMPLOYER		START DATE MM/DD/YYYY
ADDRESS		END DATE MM/DD/YYYY
CITY	PROVINCE/STATE	COUNTRY
		POSTAL CODE/ ZIP CODE

NAME OF CLINIC OR EMPLOYER		START DATE MM/DD/YYYY
ADDRESS		END DATE MM/DD/YYYY
CITY	PROVINCE/STATE	COUNTRY
		POSTAL CODE/ ZIP CODE

NAME OF CLINIC OR EMPLOYER		START DATE MM/DD/YYYY
ADDRESS		END DATE MM/DD/YYYY
CITY	PROVINCE/STATE	COUNTRY
		POSTAL CODE/ ZIP CODE

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9. ENGLISH LANGUAGE PROFICIENCY

- Is English your first language? Yes No
- Have you completed high school and/or post-secondary education in Canada or another country where the primary language of instruction is English? Yes No
- Other languages in which you can personally and competently provide professional services:

If you answered “no” to both questions, you must provide the results of an approved English Proficiency Test.

Note: Test scores more than four years old will not be accepted.

10. PROFESSIONAL AFFILIATIONS

- Have you practiced as an acupuncturist OR other type of regulated healthcare provider for any length of time in Alberta or another jurisdiction? Yes No

If yes, please complete the following and request a Letter of Standing at the end of the application from those regulatory authorities to be mailed directly to the College of Acupuncturists of Alberta:

NAME OF REGULATORY BODY			REGISTRATION/LICENSE No.
PROVINCE/STATE	COUNTRY	START DATE MM/DD/YYYY	END DATE MM/DD/YYYY

NAME OF REGULATORY BODY			REGISTRATION/LICENSE No.
PROVINCE/STATE	COUNTRY	START DATE MM/DD/YYYY	END DATE MM/DD/YYYY

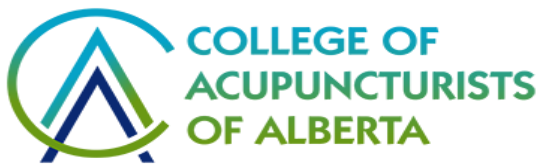
11. CHARACTER AND REPUTATION

a. CRIMINAL RECORD AND VULNERABLE SECTOR CHECK

- Attached is an original Criminal Record AND Vulnerable Sector Check. **(Dated within 30 days of this application)**

Note: The name appearing on the Criminal Record and Vulnerable Sector Check must match the name appearing on the registration application. The report must also indicate that a search was completed on all names the applicant is currently using or has previously used.

- I declare that I have not been found guilty or convicted of a Criminal or Drug Offence in any other Country. If you have been found guilty or convicted of a Criminal or Drug Offence in another Country, please provide details.



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b.1 REFERENCE INFORMATION

An applicant for registration must submit 2 written references with respect to the applicant’s acupuncture practice, which may be from an employer, educational institution or, where applicable, colleagues. The written references must be mailed directly to the College of Acupuncturists of Alberta by the person providing the reference. **(All references must be dated within 30 days of this Application.)**

This character declaration is on behalf of **(print applicant’s name)** _____

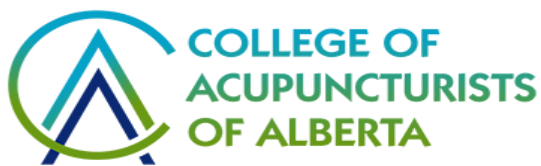
- Are you a family member of the applicant? Yes No
- Do you consider the applicant to be reliable? Yes No Insufficient knowledge of applicant to answer
- Do you consider the applicant to be ethical? Yes No Insufficient knowledge of applicant to answer
- Do you consider the applicant to be of good character? Yes No Insufficient knowledge of applicant to answer

LEGAL LAST NAME	LEGAL FIRST NAME	LEGAL MIDDLE NAME
OCCUPATION		PROFESSIONAL TITLE
ADDRESS		DURATION OF RELATIONSHIP
CITY	PROVINCE/STATE	POSTAL CODE/ ZIP CODE
		DAYTIME PHONE NUMBER

Please describe how you know the applicant as well as your knowledge about the applicant’s acupuncture practice.

SIGNATURE	DATE MM/DD/YYYY
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When complete, please send this form to:
registration@acupuncturealberta.ca



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b.2 REFERENCE INFORMATION

An applicant for registration must submit 2 written references with respect to the applicant's acupuncture practice, which may be from an employer, educational institution or, where applicable, colleagues. The written references must be mailed directly to the College of Acupuncturists of Alberta by the person providing the reference.

REFERENCE #2

This character declaration is on behalf of **(print applicant's name)** _____

- Are you a family member of the applicant? Yes No
- Do you consider the applicant to be reliable? Yes No Insufficient knowledge of applicant to answer
- Do you consider the applicant to be ethical? Yes No Insufficient knowledge of applicant to answer
- Do you consider the applicant to be of good character? Yes No Insufficient knowledge of applicant to answer

LEGAL LAST NAME	LEGAL FIRST NAME	LEGAL MIDDLE NAME
OCCUPATION		PROFESSIONAL TITLE
ADDRESS		DURATION OF RELATIONSHIP
CITY	PROVINCE/STATE	POSTAL CODE/ ZIP CODE
		DAYTIME PHONE NUMBER

Please describe how you know the applicant as well as your knowledge about the applicant's acupuncture practice.

SIGNATURE	DATE MM/DD/YYYY
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When complete, please send this form to:
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c. DECLARATION OF CONDUCT	
Are you currently undergoing an investigation, alternative complaint resolution process, hearing or appeal related to unprofessional conduct in relation to the acupuncturist profession or another profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you previously been disciplined by an organization responsible for the regulation of acupuncturists or another	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had any conditions imposed on your practice of acupuncture or another profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever made an application for registration as an acupuncturist or traditional Chinese medicine practitioner in another jurisdiction that was refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever pleaded guilty or been found guilty of a criminal offence in Canada or in any other jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has there ever been a judgement in a civil action against you with respect to your practice of acupuncture or another profession?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a mental or physical condition that could affect your ability to practise as an acupuncturist safely and competently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "Yes" to any of the above questions, please attach a detailed explanation and relevant documents to the application.	

12. FIRST AID AND CPR CERTIFICATION
<input type="checkbox"/> Attached is proof of current First Aid at Standard Level and CPR Certification Level C.

13. PERSONAL LIABILITY INSURANCE
<input type="checkbox"/> Enclosed is a copy of my professional liability insurance certificate that meets the minimum coverage required by the Council.

14. FEES	
Application Fee (Non-refundable) - \$300.00	
*Practice Permit fees are due upon notice of approved registration application.	
STARTING DATE	GENERAL PRACTICE PERMIT (QUARTERLY PRO-RATED)
April 1, 2022 - March 31, 2023	\$1200.00
July 1, 2022 - March 31, 2023	\$900.00
October 1, 2022 - March 31, 2023	\$600.00
January 1, 2023 - March 31, 2023	\$300.00

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15. PAYMENT OPTIONS

Payment option 1 – Credit Card/Debit Visa

Payable on Alinity upon receipt of completed application

Payment option 2 – Alternate

Cheque Chq #: _____

- Cheques can be made payable to the College of Acupuncturists of Alberta. **Application will be processed 10 days after cheque is received by the office.**
- Money orders and cheques can be sent directly to:
COLLEGE OF ACUPUNCTURISTS OF ALBERTA
#201, 9612-51 AVENUE, EDMONTON, AB T6E 5A6

16. APPLICANT'S DECLARATION

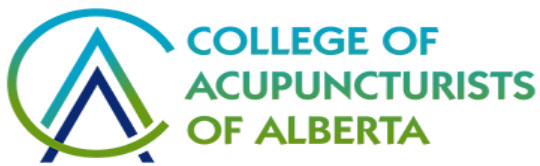
- a. I solemnly declare that all the information and statements made in this application including all attachments are true and complete to the best of my knowledge and belief. I understand and agree that if a practice permit should be issued to me based on a false or misleading statement or representation made in my application, the practice permit is subject to immediate cancellation.
- b. I understand that acupuncture is a restricted activity as per Government Organization Act, Schedule 7.1, and that it is an offence to perform a restricted activity without proper authorization. I declare that I will not perform acupuncture treatment prior to receiving a practice permit and, where applicable, will comply with any conditions imposed on my practice permit.
- c. I acknowledge that the College of Acupuncturists of Alberta collects the information required in the application form for the purpose of registration within the province of Alberta, and the information is only used or shared as regulated by the *Health Professions Act*.
- d. I undertake to immediately inform the College of Acupuncturists of Alberta in writing if any information on this form changes.
- e. I am aware that CAA may need to verify the information provided, and therefore CAA may need to disclose my information to third parties. I consent to such disclosure. I also consent to third parties disclosing my personal information to CAA, so that CAA can process my application and verify the information I have provided. Any information gathered can also be used in processing any future applications for registration with the CAA.

MM/DD/YYYY

Applicant Signature

Date

Please return your completed application and all necessary documents via email to registration@acupuncturealberta.ca in PDF format. Do not send multiple emails.



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LETTER OF STANDING

If you have practiced 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.

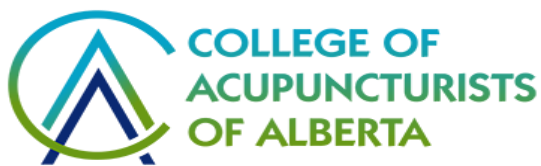
SECTION 1: CONSENT TO RELEASE OF INFORMATION

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:



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SECTION 2: LETTER OF STANDING

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

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

OR

Email: registration@acupunctrealberta.ca

Registrant Information

Full Legal Name of Registrant:	Registration/License Number:
Date of Initial Registration:	Date of Registration Expiry:
Current Registration Status (Active; Suspended; Cancelled; Lapsed):	Registration Designation (titles authorized):

Registration Record (suspension, cancellation, lapses or breaks in registration, if applicable.)		
Date	Status	Reason for change

Professional Conduct Record

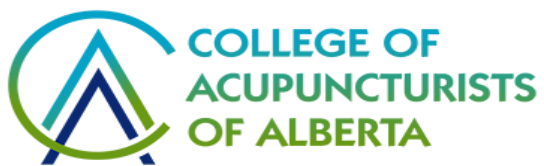
Has the registrant ever been the subject of a complaint, investigation or disciplinary proceeding respecting their practice, conduct, competence or professionalism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the registrant ever had conditions, limitations or restrictions imposed on 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 practice requirements (e.g. practice hours)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the registrant ever failed to comply with continuing competence/education requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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



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Other Relevant Information

Does the registrant currently maintain a status of good standing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the registrant ever been delinquent with fee payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If necessary, 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:

Registrar's Signature

Please affix seal in space above.