



# APPLICATION FOR REGISTRATION AS AN ACUPUNCTURIST – CURRENT BC, ONT, QUE AND NFLD REGISTRANTS (LMA)

## INSTRUCTIONS

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](mailto: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
TITLE (MS./MRS./MR.)	GENDER	DATE OF BIRTH MM/DD/YYYY
Have you previously applied for registration with the College? <div style="text-align: center;"> <input type="checkbox"/> NO      <input type="checkbox"/> YES <b>if so</b>, please complete the next section         </div>		
<input type="checkbox"/> REGISTERED MEMBER Registration # _____		<input type="checkbox"/> EXAMINATION CANDIDATE Date application was submitted _____

## 1. MAILING ADDRESS

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

## 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
EMAIL ADDRESS	PHONE NUMBER
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4. CITIZENSHIP
Are you a citizen or permanent resident of Canada?
<input type="checkbox"/> <b>Yes</b> – enclose a clear photocopy of your Canadian passport, Canadian citizen card, birth certificate or Canadian permanent resident card
<input type="checkbox"/> <b>No</b> – 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 <i>MM/DD/YYYY</i>	GRADUATION DATE <i>MM/DD/YYYY</i>	
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 <i>MM/DD/YYYY</i>	GRADUATION DATE <i>MM/DD/YYYY</i>	
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 <i>MM/DD/YYYY</i>	GRADUATION DATE <i>MM/DD/YYYY</i>	
NAME OF EDUCATIONAL INSTITUTION			GRADUATION DATE <i>MM/DD/YYYY</i>
ADDRESS			INSTRUCTION LANGUAGE
CITY	PROVINCE/STATE	COUNTRY	POSTAL CODE/ ZIP CODE

NAME OF PROGRAM	PROGRAM START DATE <i>MM/DD/YYYY</i>	GRADUATION DATE <i>MM/DD/YYYY</i>	
NAME OF EDUCATIONAL INSTITUTION			GRADUATION DATE <i>MM/DD/YYYY</i>
ADDRESS			INSTRUCTION LANGUAGE
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**7. ENGLISH LANGUAGE PROFICIENCY**

- Were you required to demonstrate proficiency in English before you received certification in your current province or territory in Canada?
  - Yes, please attach proof of completion     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

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

Other languages in which you can personally and competently provide professional services:

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**8. 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, located at the end of this application, from those regulatory authorities and to be mailed directly to the College of Acupuncturists of Alberta.

NAME OF REGULATORY BODY		REGISTRATION/LICENSE No.	
INITIAL REGISTRATION DATE MM/DD/YYYY	REGISTRATION EXPIRY DATE MM/DD/YYYY		
NAME OF CLINIC OR EMPLOYER		EMPLOYMENT START DATE MM/DD/YYYY	
ADDRESS		EMPLOYMENT END DATE MM/DD/YYYY	
CITY	PROVINCE/STATE	COUNTRY	POSTAL CODE/ ZIP CODE

NAME OF REGULATORY BODY		REGISTRATION/LICENSE No.	
INITIAL REGISTRATION DATE MM/DD/YYYY	REGISTRATION EXPIRY DATE MM/DD/YYYY		
NAME OF CLINIC OR EMPLOYER		EMPLOYMENT START DATE MM/DD/YYYY	
ADDRESS		EMPLOYMENT END DATE MM/DD/YYYY	
CITY	PROVINCE/STATE	COUNTRY	POSTAL CODE/ ZIP CODE

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### 9. JURISPRUDENCE EXAMINATION

Normally, applicants under the Labour Mobility Act (LMA) are required to pass the Jurisprudence Examination before their registration. However, the Jurisprudence Examination under the Health Professions Act is currently unavailable.

I understand that it is my responsibility to learn and comply with the requirements set out in the Act, Regulation, the CAA Bylaws, Code of Professional Conduct, CAA Safety Handbook and the CAA policies and standards, such as, Patient Record Policy and Sexual Abuse and Sexual Misconduct Policy.

MM/DD/YYYY

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

### 10. 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. Criminal record and Vulnerable Sector Checks are valid for three (3) months.*

### 11. 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 profession?	<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 been found guilty or convicted of a criminal or drug 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.

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**12. ADDITIONAL DOCUMENTATION**

- Attached is proof of current First Aid at Standard Level and CPR Certification Level C. (Minimum)
- Attached is a copy of the completion certificate of the mandatory sexual abuse and sexual misconduct prevention training. <https://afrhp.org/bill21-protecting-patients/>
- I understand that I will need to provide a copy of my professional liability insurance certificate that meets the minimum coverage of at least \$2, 000, 000 per claim/occurrence pending approval of this application.

**13. 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 <sup>st</sup> - March 31 <sup>st</sup>	\$1200.00
July 1 <sup>st</sup> - March 31 <sup>st</sup>	\$900.00
October 1 <sup>st</sup> - March 31 <sup>st</sup>	\$600.00
January 1 <sup>ST</sup> - March 31 <sup>st</sup>	\$300.00

**14. PAYMENT OPTIONS**

**Credit Card/Debit Visa**

Payable on Alinity upon receipt of completed application

**Alternate**

- E-transfer to [payment@acupuncturealberta.ca](mailto:payment@acupuncturealberta.ca).

**Please ensure you enter the following information in the message field: name, registration number and what the funds are for ((ie: application fee, registration fees, etc.)**

- 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**

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15. 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 will disclose any physical or mental condition(s) or disorder(s) that may impair my ability to provide safe, competent, and ethical care. These conditions may include mental illness, physical illness, substance abuse, and addictions. This may include, but not limited to, my information under the care of a physician or healthcare team and any medical treatment and advice I am following.
- d. 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*.
- e. I undertake to immediately inform the College of Acupuncturists of Alberta in writing if any information on this form changes.
- f. 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](mailto: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@acupuncturealberta.ca](mailto:registration@acupuncturealberta.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:

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**Registrar's Signature**

**Please affix seal in space above.**