COLLEGE OF ACUPUNCTURISTS OF ALBERTA

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 reinstatement as an acupuncturist in Alberta.

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 and documents must be sent via email in PDF format to registration@acupuncturealberta.ca. Do not send multiple emails.**

CAA Initial registration date _____MM/DD/YYYY_____

Last date of practice as an acupuncturist in Alberta _____MM/DD/YYYY_____

Reinstatement start date **(Please allow for up to four (4) weeks for application to be processed)** _____MM/DD/YYYY_____

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 REGISTERY

CLINIC ADDRESS	APT/SUITE/UNIT

CITY	PROVINCE	POSTAL CODE

EMAIL ADDRESS	PHONE NUMBER

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

Have you completed your acupuncture education program within the last three (3) years?

If yes, complete the following section and attach official transcripts and a copy of your diploma/certificate to this application.

If no, please complete the following section and attach the listed documentation:

- official transcripts and a copy of your diploma/certificate
- appointment records for the past three (3) years; **OR**
- employment verification letter for the past three years.

Appointment records or an employment verification letter should demonstrate a minimum of 600 hours of acupuncture practice in the past three years.

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

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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

7. REGISTRATION EXAMINATIONS

Applicants must provide information about passed Alberta Acupuncturist Registration Examinations or licensing examination as an acupuncturist in North America or elsewhere.		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
NAME OF EXAMINATION	JURISDICTION	DATE OF EXAMINATION MM/DD/YYYY
NAME OF EXAMINATION	JURISDICTION	DATE OF EXAMINATION MM/DD/YYYY

8. 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.

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9. 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

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

COLLEGE OF ACUPUNCTURISTS OF ALBERTA

APPLICATION FOR REGISTRATION AS AN ACUPUNCTURIST (REINSTATEMENT)

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

When complete, please send this form to:

registration@acupuncturealberta.ca

COLLEGE OF ACUPUNCTURISTS OF ALBERTA

APPLICATION FOR REGISTRATION AS AN ACUPUNCTURIST (REINSTATEMENT)

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

When complete, please send this form to:

registration@acupuncturealberta.ca

COLLEGE OF ACUPUNCTURISTS OF ALBERTA

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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?	☐ Yes ☐ No
Have you previously been disciplined by an organization responsible for the regulation of acupuncturists or another	☐ Yes ☐ No
Have you ever had any conditions imposed on your practice of acupuncture or another profession?	☐ Yes ☐ No
Have you ever made an application for registration as an acupuncturist or traditional Chinese medicine practitioner in another jurisdiction that was refused?	☐ Yes ☐ No
Have you ever been found guilty or convicted of a criminal or drug offence in Canada or in any other jurisdiction?	☐ Yes ☐ No
Has there ever been a judgement in a civil action against you with respect to your practice of acupuncture or another profession?	☐ Yes ☐ No
Do you have a mental or physical condition that could affect your ability to practise as an acupuncturist safely and competently?	☐ Yes ☐ No
If you answered "Yes" to any of the above questions, please attach a detailed explanation and relevant documents to the application.	

11. 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.

12. 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 1st - March 31st	$1200.00
July 1st - March 31st	$900.00
October 1st - March 31st	$600.00
January 1ST - March 31st	$300.00

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13. PAYMENT OPTIONS

Credit Card/Debit Visa

Payable on Alinity upon receipt of completed application

Alternate

☐ E-transfer to 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

14. 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**

COLLEGE OF ACUPUNCTURISTS OF ALBERTA

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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

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?	□ Yes □ No
Has the registrant ever had conditions, limitations or restrictions imposed on their practice permit?	□ Yes □ 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)?	□ Yes □ No
Has the registrant ever failed to comply with continuing competence/education requirements?	□ Yes □ No

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

APPLICATION FOR REGISTRATION AS AN ACUPUNCTURIST (REINSTATEMENT)

Other Relevant Information

Does the registrant currently maintain a status of good standing?	□ Yes □ No
Has the registrant ever been delinquent with fee payments?	□ Yes □ 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.**