

College of Naturopathic Physicians of British Columbia

FORM

Application for Certification in *Advanced Injection Therapies* – Part B

Privacy and Security

The information you provide here relates to the operations of the College of Naturopathic Physicians of British Columbia (the “College”) under the *Health Professions Act* of British Columbia for the purpose of regulating the practice of naturopathic medicine in British Columbia. As a public body under the provisions of the *Freedom of Information and Protection of Privacy Act (FOIPPA)*, the College provides security and confidentiality of your personal information.

IMPORTANT: *The College reviews applications in the order in which they are received. Application fees are processed prior to review. You will be notified as to whether your application was successful. You must not perform treatment involving the associated Advanced Injection Therapies until you have received written confirmation from the College that you hold a certification in this aspect of practice. For more information about Advanced Injection Therapies – Parts A and B, see the College’s website: <http://www.cnpbc.bc.ca/for-registrants/resources/certification-requirements/advanced-injection-therapies/>*

APPLICANT INFORMATION		
Given name(s):	Registration (Licence) Number:	
Surname:	<div style="display: flex; justify-content: space-around; align-items: center;"> </div>	
Class of Registration: <input type="checkbox"/> Full (Practising) <input type="checkbox"/> Temporary <input type="checkbox"/> Non-Practising <input type="checkbox"/> Former		
Primary Place of Practice Address:		
City:	Prov./Terr.:	Postal Code:
Telephone:	Fax:	Email:

List any addresses where the Applicant carries on the business of providing the services of naturopathic medicine. If additional space is required, please attach a separate page to this application. (To report a new practice location or update location information, please download a “Places of Practice Information Form” from the College website and attach it to this application.)

College of Naturopathic Physicians of British Columbia

APPLICANT ATTESTATION (required):

I, _____, declare that:

Name of Applicant

I am a full (practising) registrant of the College under section 46 of the Bylaws.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I hold a valid College certification in <i>Prescriptive Authority</i> .	<input type="checkbox"/> Yes <input type="checkbox"/> No
I hold a valid College certification in <i>Advanced Injection Therapies – Part A</i> .	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have completed a course in NCLS or ACLS within the past two years, and attach a copy of my course completion certificate.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have completed a course or courses in satisfaction of the requirements for certification in <i>Advanced Injection Therapies – Part B</i> , and attach a copy of the corresponding course completion certificate(s).	<input type="checkbox"/> Yes <input type="checkbox"/> No
I certify that the information contained in this application is true, complete, and accurate to the best of my knowledge.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant's Signature

Date Applied (yyyy/mm/dd)

FOR OFFICE USE ONLY

Full registrant

Rx authority date _____

ACLS / NCLS date _____

Evidence of Course completion
date _____

Signature

Date (yyyy/mm/dd)

APPLICATION CHECKLIST – In support of this application, please attach the following:

- Evidence of successful completion of a course or courses in satisfaction of the requirements for certification in *Advanced Injection Therapies – Part B*
- Certificate of course completion for a course in Naturopathic Cardiac Life Support (NCLS) or Advanced Cardiac Life Support (ACLS) from within the past two years
 - o <- Please indicate here if the College already has these records on file
- Certification application fee of \$150.00, payable to the **‘College of Naturopathic Physicians of British Columbia’** (see below re: PAYMENT)

PAYMENT	
<p>Please check the box to indicate the method of payment, and enclose payment if applicable.</p>	
<input type="checkbox"/> Bank Draft/Money Order	
<input type="checkbox"/> Certified Cheque	
<input type="checkbox"/> Visa/MC Account # _____	Expiry: (mm) _____(yyyy) _____
Security # (three digit number on back of card) _____	
_____	_____
<i>Applicant's Signature</i>	<i>Date (yyyy/mm/dd)</i>

INFORMATION FOR SUBMITTING YOUR APPLICATION

Sign and return form to the College of Naturopathic Physicians of British Columbia.

By mail: 840-605 Robson Street, Vancouver BC V6B 5J3

By fax: (604) 688-8476

By email: office@cnpbc.bc.ca

***If you have any questions regarding this process,
please feel welcome to contact the College and staff will be pleased to assist you.***

Phone: (604) 688-8236