FORM

Application for Certification in *IV & Chelation Therapies*

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.*

APPLICANT INFORMATION			
Given name(s):			Registration (Licence) Number: 0 0 ___ ___ ___
Surname:			
Class of Registration: ☐ Full (Practising) ☐ Temporary ☐ Non-Practising ☐ 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.)*

APPLICANT ATTESTATION (required):

I, _____, declare that:

Name of Applicant

I am a full (practising) registrant of the College under section 46 of the Bylaws.	☐ Yes ☐ No
I hold a valid College certification in *Prescriptive Authority*.	☐ Yes ☐ No
I hold a valid College certification in *IV Therapy*.	☐ Yes ☐ No
I have completed a course in NCLS or ACLS within the past two years, and attach a copy of my course completion certificate.	☐ Yes ☐ No
I have completed a course or courses in satisfaction of the requirements for certification in *IV & Chelation Therapies*, and attach a copy of the corresponding course completion certificate(s).	☐ Yes ☐ No
I certify that the information contained in this application is true, complete, and accurate to the best of my knowledge.	☐ Yes ☐ 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 *IV & Chelation Therapies*
- ☐ 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
Please check the box to indicate the method of payment, and enclose payment if applicable. ☐ Bank Draft/Money Order ☐ Certified Cheque ☐ Visa/MC Account # _____Expiry: (mm) _____(yyyy) _____ Security # (three digit number on back of card) _____ _____ _____ *Applicant's Signature* *Date (yyyy/mm/dd)*

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