College of Naturopathic Physicians of British Columbia

FORM

Supplementary Information for Certification Application

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.

Affix this form and the requested information in support of your application for certification.

Applicant Information			
Given name(s):			Registrant (Licence) Number:
Surname:			
Class of Registration: ☐ Full (Practising) ☐ Temporary			
Mailing Address:			
City:		Province/Territory:	Postal Code:
Telephone:	Fax:	Email:	

Certification Information
Certification sought:
Details:

Please provide the following information and attach any supporting documentation.

Person/institute/organization that delivered training received:	
Length of training received, and details regarding training (didactic/theoretical vs hands-on/practical):	
Length of time actively practicing specified aspect of practice:	
Approximate number of patients treated this year using specified modality:	

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)* *Date Approved (yyyy/mm/dd)*