



# Reinstatement Intake

## System transition Paper Form

*The purpose of this form is to collect the information required for staff to manually process your application. Please ensure all sections of the form are completed in full.*

### **Personal Information**

Full name:

Licensee (registration) number:

Profession:

Phone:

Email:

### **Reinstatement type**

Within 3 months of holding active status

Within 3 months to 3 years of holding active status

Over 3 years since last held active status

### **Required Documents**

(Please submit the below documents along with this application form).

Identification Document

Professional Liability Insurance

Standard First Aid/CPR-C (BLS-HCP for naturopathic medicine)

Letter of Good Standing (if applicable)



Consent to Criminal Records Check Form (CRC)

Outstanding Continuing Education (CE)

Declarations

Other:

Applicant Signature \_\_\_\_\_ Date (YY-MM-DD) \_\_\_\_\_

**Office use only**

Name of staff reviewing application:

Date (YY-MM-DD) and time application was received:

Notes/Flags: (Disclosures, special circumstances, missing documents)

**Payment Information**

Amount: \$

Method:      Credit Card      Cheque      Other