

2010 Registration Renewal

For Office Use Only	
Registration Approved Yes <input type="checkbox"/> No <input type="checkbox"/>	Registry Number _ _ _ _ _
Registered with Restrictions &/or Conditions: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Registration:
Requires training? Yes <input type="checkbox"/> No <input type="checkbox"/>	Conditions must successfully be completed by:
Training &/or restrictions/conditions:	

1. PERSONAL INFORMATION

Surname	Given Name	Middle Initial	Registry #
Mailing Address		City/Town	Province
Postal Code	Home Phone	Work Phone	Cell Phone
Date of Birth	Email Address		Male <input type="checkbox"/> Female <input type="checkbox"/>
Former Name(s):			
If you have changed your name since the last renewal period, you must provide a copy of the legal document showing the name change. This document could be a marriage certificate, a divorce certificate or some other legal document.			

2. TYPE OF LICENSE REQUESTED:

Level of Practice:

EMR <input type="checkbox"/>	EMT <input type="checkbox"/> or EMT/PCP Trained <input type="checkbox"/>	EMT-A <input type="checkbox"/> or EMT-A/ICP Trained <input type="checkbox"/>	EMT-P <input type="checkbox"/> or EMT-P/ACP Trained <input type="checkbox"/>
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Status:

Practising <input type="checkbox"/> or Non practising (may not work or volunteer in scope of practice) <input type="checkbox"/>

3. FEES

2010 Annual License \$425.00 Pro-rated License (after Oct 1, 2010) \$255.00 Non-practising License \$50.00
Late Fee: \$50, payable on December 2 and will escalate weekly to: \$75 on Dec. 7, \$100 on Dec 14, \$125 on Dec. 21, \$150 on Dec 28, \$175 on Jan 4/10, \$200 on Jan 11/10, \$225 on Jan 18/10, \$250 on Jan 25/10, after Jan 31/2010, the member must apply for reinstatement. Reinstatement Fee \$275.00

METHOD OF PAYMENT:

Certified cheques, company cheques, money order, Visa, MasterCard are accepted.

Personal cheques will not be accepted and will be returned.

Money Order/ Certified Cheque

EMPLOYER CHEQUE NAME OF EMPLOYER _____

Visa/MasterCard # _____ Expiry Date _____

Name/Signature of Cardholder (other than Registrant) _____

Print Name of Cardholder _____

4. REGISTRATION IN OTHER JURISDICTIONS OR PROFESSIONS:

In which other provinces or countries are you licensed/registered as a paramedic? (EMR, EMT, etc.)

Please provide a copy of your license.

In which other professions/trades do you hold a current license/registration?

Please provide a copy of your license.

5. CRIMINAL RECORD CHECK Complete A **or** B below

A. DECLARATION:
 To the best of my knowledge, I, the applicant, declare that I have not been charged with, or convicted of, an offence under *The Criminal Code, Controlled Drugs and Substances Act* or *The Food and Drugs Act* within the past three years.
OR

B. DECLARATION:
 Within the past three years, I, the applicant, have been charged/convicted of an offence under *The Criminal Code, The Controlled Drugs and Substances Act* or *The Food and Drugs Act*.
 Attach a certified criminal record or court document which details the charge(s), conviction(s) and disposition of each. Further information may need to be provided on request from the Registrar.

6. DISCIPLINARY ACTION Complete A **or** B below

A. DECLARATION:
 I declare that my license has **not** been cancelled, suspended, restricted or subject to individual terms and conditions by any regulatory authority or health profession in any jurisdiction in the past 3 years. **OR**

B. DECLARATION:
 My license has been cancelled, suspended, restricted or subject to individual terms and conditions by a regulatory authority or health profession in any jurisdiction in the past 3 years.
 Please provide the following information if you have answered Part B.

Name and Address of Organization:

Reason for Disciplinary Action:

Nature of the Disciplinary Action:

Date of the Disciplinary Action:

Terms of Conditions which **currently** affect your license:

I grant the Saskatchewan College of Paramedics the right to contact the above organization for further clarification if necessary.

***SIGNATURE REQUIRED**

I declare that I have, to the best of my knowledge, truthfully answered Sections 4, 5 and 6.

Signature of Applicant

Date

7. EMPLOYMENT STATUS

Current Position: (or primary position if you are currently employed in more than one position)

Full Time <input type="checkbox"/> <small>(You have a full time position)</small>	Part Time <input type="checkbox"/> <small>have regular scheduled hrs, but not a full time position</small>	(You	Casual <input type="checkbox"/>	Volunteer <input type="checkbox"/>
Employer and Name of Service (eg. RQHR, Regina EMS)			From Date	To Date
Employer Address				
Employer Contact Name and Phone #				
Service Type: Ambulance <input type="checkbox"/> Fire <input type="checkbox"/> Industrial <input type="checkbox"/> Educational <input type="checkbox"/> Facility Based <input type="checkbox"/> Other <input type="checkbox"/>				
Approximate # of Calls in 2009:			# of patients as lead attendant in 2009:	

Second Position: (if you are employed in another position)

Full Time <input type="checkbox"/> <small>(You have a full time position)</small>	Part Time <input type="checkbox"/> <small>have regular scheduled hrs, but not a full time position</small>	(You	Casual <input type="checkbox"/>	Volunteer <input type="checkbox"/>
Employer and Name of Service (eg. RQHR, Regina EMS)			From Date	To Date
Employer Address				
Employer Contact Name and Phone #				
Service Type: Ambulance <input type="checkbox"/> Fire <input type="checkbox"/> Industrial <input type="checkbox"/> Educational <input type="checkbox"/> Facility Based <input type="checkbox"/> Other <input type="checkbox"/>				
Approximate # of calls in 2009:			# of patients as lead attendant in 2009:	

8. PRIVACY

The Saskatchewan College of Paramedics (SCoP) collects, uses and discloses personal information as reasonably necessary for the purposes of performing and fulfilling its responsibilities under *The Paramedics Act* and the *Bylaws*. The SCoP stores and maintains personal information in conformity with the requirements of the *Personal Information Protection and Electronic Documents Act (PIPEDA)* and the *Health Information Protection Act (HIPA)*.

PRIVACY WAIVER (must be completed if your agency is handling your registration)

I grant permission to _____ (facilitator, proctor, coordinator) of _____ (agency) to have access to my file and discuss it with staff at SCoP for purposes of facilitating my license renewal or changes to my license during the coming year.

Signature

DECLARATION:

To the best of my knowledge, I, the applicant, declare that all the information given on this application is true. I understand that any false or misleading information may constitute professional misconduct and could lead to disciplinary action.

Signature of Applicant

Date

Checklist:

- REGISTRATION FORM:** Have you signed the registration form on page 2 and twice on page 3?
- CME REPORT FORM:** Have you signed and attached your completed CME REPORT FORM? The appropriate form for your level of practice can be found on our website www.collegeofparamedics.sk.ca.
- CERTIFICATES:** Have you attached copies of all mandatory certificates for your level of practice?
- MAIL:** application, payment and all required documents to: **Saskatchewan College of Paramedics
851 Argyle St. N., Regina, SK S4R 8H1**