

APPLICATION FOR REINSTATEMENT



PLEASE SUBMIT ALL PAYMENTS TO: NSAMRT REGISTRAR
c/o NOVA SCOTIA ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS
3205 Mayfield Ave, Halifax, NS, B3I 4B4



NAME: Mr. / Mrs. / Ms. / Miss (Surname/Given)	Former Name/Nee	CAMRT #
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Address	City & Postal Code
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Telephone: Home: _____	E-mail: _____
Work: _____	E-mail: _____

Date of Birth Year/ _____ Month/ _____ Day/ _____

Radiological Technologist <input type="checkbox"/>	Radiation Therapy <input type="checkbox"/>	Nuclear Medicine <input type="checkbox"/>	Magnetic Resonance <input type="checkbox"/>
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EMPLOYMENT INFORMATION (past 5 years)
Please include "PROOF OF COMPETENCY" if Non-Membership status is more than Five (5) years

Dates (from-to)	Institution	City	Mgr/Chief

Any current disciplinary action? Yes No If yes, please use the reverse side of the form to explain

Any complaint of Professional Misconduct against you? Yes No If yes, please use the reverse side of the form to explain

Enclosed is the administrative fee of \$ _____ and/or current membership dues of \$ _____ TOTAL \$ _____

Method of Payment: Cheque Money Order

Date _____ Signature _____

NSAMRT Use Only

Last Paid Dues?	Resigned? <input type="checkbox"/>	Membership Lapsed? <input type="checkbox"/>
Date Rec'd from Applicant:	Date of Cheque/Payment:	Date Sent to CAMRT:

We hereby verify that this applicant HAS fulfilled the requirements for reinstatement and the NSAMRT does recommend them for reinstatement

Date: _____ Signature: _____

For CAMRT Use Only

Date received	Date Approved	Initial
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