APPLICATION FOR REIMBURSEMENT of DUES

Please Submit Completed Form to:

Nova Scotia Association of Medical Radiation Technologists
P.O. Box 9410, Station A Halifax, NS B3K 5S3
Fax: 902-832-8676 Email: info@nsamrt.ca

Name: Mr./Mrs./Ms./Miss (Surname, Given)	**Former Name/Nee:**	**NSAMRT#:**
Address:	**City & Postal Code:**	

Telephone: _____ **Email:** _____

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

Radiological Technology ☐	Radiation Therapy ☐	Nuclear Medicine ☐	Magnetic Resonance ☐

Actual Date Resigned _____

I understand that I must complete a NSAMRT Reinstatement form, submit all required documentation and pay all fees in full *before* returning to work. Forms and other requirements for reinstatement can be located @ www.nsamrt.ca
*** Reinstatement within the same calendar year of Reimbursement may be subject to full annual dues.**

Signature _____ **Date** _____

Employer/Physician Use Only

*If you have more than one Employer, each one must sign this form
* If the resignation is due to a medical leave, your physician must sign this form as well

Applicant Name: _____

Actual Start Date of Leave: _____ **Expected Date of Return:** _____

Please select reason for Resignation/Leave of Absence:

Maternity ☐	Medical ☐	Retirement ☐	Unemployment ☐	Other_____ ☐

I hereby verify that, to my knowledge, the information in this form is correct and the applicant is not currently practicing as a MRT.

Signature _____ **Date:** _____

Name (print) _____

Signature _____ **Date:** _____

Name (print) _____

NSAMRT Approval Signature