Print Form

PRE-REGISTRATION FORM FOR APPLICANTS EDUCATED OUTSIDE OF CANADA

1. PERSONAL DATA

First name Middle name Last name

Previous name (if applicable)

Date of birth (yyyy/mm/dd)

Gender ☐ Male ☐ Female

Have you applied for registration in another province / jurisdiction?

☐ No ☐ Yes, please specify

2. HOME ADDRESS / CONTACT INFORMATION

Street Address: Apt / Suite No.:

City: Province / State:

Postal / Zip Code: Country:

Home Telephone: Mobile:

email:

3. RESIDENCY STATUS (please provide required documentation)

☐ I am a Canadian Citizen.
☐ I am a Permanent Resident / Landed Immigrant of Canada.
☐ Other (e.g. student visa, work permit, etc.). Please provide details:

4. LANGUAGE PROFICIENCY

First language ☐ English ☐ Other (specify)

Language of respiratory education (or related field)

☐ English ☐ Other (specify)

Language in which you can personally and competently provide respiratory therapy services

☐ English ☐ Other (specify) _____

If your language is not English, and your relevant health care education was not in English, you will need to submit documentation to demonstrate fluency in English.

For further information, see link to Language Proficiency Requirements

5. RESPIRATORY THERAPY EDUCATION (OR OTHER FIELD OF PRACTICE)

Name of program of study _____

Credential ☐ Diploma ☐ Baccalaureate ☐ Other (specify) _____

Name of educational facility: _____

Country: _____

Year of Graduation: _____

Length of Study _____ no. of years _____ no. of semesters

Language of instruction _____

External credential review report ☐ WES Canada ☐ Other (specify) _____

Did the program cover the following topics during the academic portion and/or didactic semesters – for any affirmative answer below, please provide number of hours:

Anatomy / physiology	☐ No	☐ Yes	_____ Hrs
Pathophysiology	☐ No	☐ Yes	_____ Hrs
Pharmacology (respiratory, cardiac, renal, anesthesia, pain)	☐ No	☐ Yes	_____ Hrs
Airway management (neonatal, paediatric, adult)	☐ No	☐ Yes	_____ Hrs
Mechanical ventilation	☐ No	☐ Yes	_____ Hrs
Oxygen and specialty gas administration	☐ No	☐ Yes	_____ Hrs
Anesthesia care	☐ No	☐ Yes	_____ Hrs

Pulmonary function testing ☐ No ☐ Yes Hrs

Neonatal / pediatric care ☐ No ☐ Yes _____ Hrs

Other (provide details) _____ _____ Hrs

Total hours didactic: _____

Did the clinical rotations cover the following clinical sites / practice areas:

Adult critical care unit ☐ No ☐ Yes _____ Hrs

Paediatric / neonatal critical care unit ☐ No ☐ Yes _____ Hrs

Operating room ☐ No ☐ Yes _____ Hrs

Emergency / casualty department ☐ No ☐ Yes _____ Hrs

General wards ☐ No ☐ Yes _____ Hrs

Pulmonary function testing laboratory ☐ No ☐ Yes _____ Hrs

Cardiac diagnostics (i.e. holter, 12 lead ECGs) ☐ No ☐ Yes _____ Hrs

Home care (home oxygen therapy and related equipment) ☐ No ☐ Yes _____ Hrs

Other (provide details) _____ _____ Hrs

Total hours clinical: _____

6. OTHER POST SECONDARY EDUCATION

	Field of Study	Name of Academic Institution	Country	Year(s)
☐ **Certificate**				
☐ **Diploma**				
☐ **Baccalaureate**				
☐ **Master**				
☐ **Doctorate**				
☐ **Other**				

7. PROFESSIONAL PORTFOLIO

Please complete the professional portfolio which encompasses both formal and informal aspects of your education and experience.

The portfolio may be submitted in a hard copy or an electronic format.

8. PROFESSIONAL REGISTRATION

Are you or have you ever been registered and/or licensed to practice respiratory therapist, or in other health care profession(s)? ☐ Yes ☐ No

If yes, please provide the following information:

Regulatory body / Licensing body	
Registration / License Number	
Province / Jurisdiction / Country	
Expiry Date	

9. EMPLOYMENT HISTORY

Have you ever practices as a respiratory therapist or other health care provider in any jurisdiction at any time? ☐ Yes ☐ No

If yes, please list the name and address of all your employers, starting with the most recent. Please include start and finish dates. Provide a letter of reference from each employer in which you have been practicing as a respiratory therapist (or in a related field) over the past five years.

Employer | Position Held

Start Date | End Date | Employer Address

Telephone Number | E-Mail Address

Employer | Position Held

Start Date | End Date | Employer Address

Telephone Number | E-Mail Address

Employer | Position Held

Start Date | End Date | Employer Address

Telephone Number | E-Mail Address

Employer | Position Held

Start Date | End Date | Employer Address

Telephone Number | E-Mail Address

10. DECLARATION AND AUTHORIZATION

☐ I declare, and hereby certify, that the statements made in this application are complete and correct to the best of my knowledge and belief.

☐ I hereby authorize the sources referred to on this form to release to the Nova Scotia College of Respiratory Therapists all information about me in their possession for the purpose of registration / licensing.

☐ I consent to the Nova Scotia College of Respiratory Therapists provide this information to a respiratory therapy program for the purpose of my application to that program.

Signed in _____ **on this** _____ **day of** _____ **20**_____

Name of Applicant Printed

Signature of Applicant

Name of Witness Printed

Signature of Witness

Please submit your form to:

Registrar
Nova Scotia College of Respiratory Therapists
Suite 700 – 6009 Quinpool Road
Halifax, NS B3K 5J7 Canada

Email: registrar@nscrt.com
Facsimile : (902) 425-2441