Nova Scotia College of Respiratory Therapists

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 Number:

City: Province / State:

Postal/Zip Code: Country:

Home phone #: Cell: Email:

3. RESIDENCY STATUS (please provide required documents)

☐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:

Click or tap here to enter text.

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 the 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: Number of years Number 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: (if you answer yes, please provide the number of hours)

Anatomy/physiology	☐No ☐Yes	Hours
Pathophysiology	☐No ☐Yes	Hours
Pharmacology	☐No ☐Yes	Hours
Airway Management (neonatal, paediatric, adult)	☐No ☐Yes	Hours
Mechanical Ventilation	☐No ☐Yes	Hours
Oxygen and specialty gas administration	☐No ☐Yes	Hours
Anesthesia Care	☐No ☐Yes	Hours
Pulmonary function testing	☐No ☐Yes	Hours
Neonatal/pediatric care	☐No ☐Yes	Hours
Other (provide details)		Hours

Total hours didactic: Hours

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

Adult Critical care unit	☐No ☐Yes	Hours
Paediatric/neonatal critical care unit	☐No ☐Yes	Hours

Operating room	☐No ☐Yes	Hours
Emergency/casualty department	☐No ☐Yes	Hours
General wards	☐No ☐Yes	Hours
Pulmonary function testing laboratory	☐No ☐Yes	Hours
Cardiac diagnostics (i.e. holter, 12 lead ECGs)	☐No ☐Yes	Hours
Home care (home oxygen therapy and related equipment	☐No ☐Yes	Hours

Other (provide details) _____ Hours

Total hours clinical: _____ Hours

6. OTHER POST SECONDARY EDUCATION

	Field of Study	Name of Academic Institution	Country	Years
☐**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.

8. PROFESSIONAL REGISTRATIONS

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

If yes, please provide the following information:

Regulatory body/Licensing body

Registration/licence number

Province/Jurisdiction/Country **Expiry Date**

9. EMPLOYMENT HISTORY

Have you ever practiced as a respiratory therapist or other health care provider in any jurisdiction at any time? ☐Yes (provide details below) ☐No

Employer: Position held:

Start date: End date:

Employer address:

Telephone number: Email address:

Employer: Position held:

Start date: End date:

Employer address:

Telephone number: Email address:

Employer: Position held:

Start date: End date:

Employer address:

Telephone number: Email 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 provision of this information to a respiratory therapy program for the purpose of my application to that program.

Sign 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
1959 Upper Water Street, Suite 1301
Halifax, NS, Canada
B3J 3N2
Email: registrar@nscrt.com
Facsimile: 902-422-2388