

BOARD OF DIRECTORS OF DRUGLESS THERAPY - NATUROPATHY
112 Adelaide Street East
Toronto, ON M5C 1K9
tel. 416-866-8383

**APPLICATION FOR CERTIFICATION TO PRACTICE
PARENTERAL THERAPY**

Please Type or Print Clearly

Surname: _____ First Name(s): _____ Regis. # _____
As you would like it to appear on your Certificate

CLINIC ADDRESS (for PT practice)

Name of Clinic (if any): _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____ E-mail: _____

HOME ADDRESS

Street: _____ Apt. No.: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ E-mail: _____

Date of CPR training: _____ CPR Organization: _____

Malpractice Insur. carrier: _____ Policy # _____

I, _____, hereby consent to have the premises wherein I conduct parenteral therapy inspected by an inspector who is authorized by the Board of Directors of Drugless Therapy – Naturopathy to perform such inspection, in accordance with the Parenteral Therapy policy.

Signature: _____ Date: _____

Please include payment of the applicable fee by cheque payable to the *BDDT-Naturopathy* or by credit card using the Credit Card Authorization form, along with proof of your CPR course taken in the past 12 months (a copy of the CPR card or certificate) and your malpractice insurance policy which includes coverage for Parenteral (IV) Therapy.