



College and Association of Respiratory Therapists of Alberta  
 Suite #370, 6715 - 8<sup>th</sup> Street N.E., Calgary, Alberta, Canada T2E 7H7  
 Telephone (403) 274-1828 1-800-205-2778 Fax (403) 274-9703  
**APPLICATION FOR REGISTRATION AS A  
 REGISTERED RESPIRATORY THERAPIST**

*Please help us serve you better by providing all information requested. Illegible and/or incomplete information will delay application, and may subject applicant to an additional administration fee.*

**Applicant's Identification**

<b>SALUTATION</b> Mr ___ Ms ___ Mrs ___  <b>GENDER</b> M ___ F ___		<b>SURNAME</b>	<b>FIRST/GIVEN NAME</b>	<b>Initial</b>
<b>MAIDEN NAME (If Applicable)</b>			<b>DATE OF BIRTH</b> Year _____ Month _____ Day _____	
<b>PERMANENT MAILING ADDRESS</b>  				
<b>Phone Number (home)</b> _____		<b>Cell Number</b> _____	<b>Work Number</b> _____ <b>Work Fax #</b> _____	
<b>E-mail Addresses:</b> <b>Home</b> _____ <b>Work</b> _____ <b>E-mail Address of Employer:</b> _____				
<b>EMERGENCY CONTACT:</b> _____ _____ _____				

**Educational Qualifications**

<b>Name of Educational Institution Attended for Respiratory Therapy Training</b>	<b>Date of Graduation</b> Year _____ Month _____
<b>Language of Instruction:</b> _____	
<b>Are You Applying Under the Mutual Recognition Agreement (MRA)?</b>  <b>YES</b> <input type="checkbox"/> If <b>yes</b> please select which of the following organizations apply to you. ( <b>Choose only 1</b> ) <input type="checkbox"/> <b>OPIQ</b> (l'Ordre professionnel des inhalothérapeutes du Quebec) <input type="checkbox"/> <b>CRTO</b> (College of Respiratory Therapists of Ontario) <input type="checkbox"/> <b>MAART</b> (Manitoba Association of Registered Respiratory Therapists) <input type="checkbox"/> <b>CSRT</b> (Canadian Society of Respiratory Therapists)	
<p align="center"><b>The information collected on this form is for purpose of application of Part 2 of the <i>Health Professions Act</i>, subject to the confidentiality provisions of Section 52 of <i>The Act</i>.</b></p> <p align="center">Page 1 of 6</p>	



College and Association of Respiratory Therapists of Alberta

Suite #370, 6715 - 8th Street N.E., Calgary, Alberta, Canada T2E 7H7

Telephone (403) 274-1828 Fax (403) 274-9703 1-800-205-2778

APPLICATION FOR REGISTRATION AS A REGISTERED RESPIRATORY THERAPIST

NO  If no please select which of the following apply to you. (Choose as many as apply)

New Graduate

Foreign trained Respiratory Therapist

Foreign Trained Seeking Substantial Equivalency

Other \_\_\_\_\_

\_\_\_\_\_

Have you ever been disciplined or currently being investigated by any body responsible for the regulation of respiratory therapy or any other profession?

Yes

No

Have you been participating in a continuing competency program?

Yes \_\_\_\_\_

No \_\_\_\_\_

Employment History as a Respiratory Therapist (if experienced Respiratory Therapist)

Employer, Address, Phone Number, Type of Facility:

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Practice Hours: \_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Practice Hours: \_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_ Practice Hours: \_\_\_\_\_

The information collected on this form is for purpose of application of Part 2 of the Health Professions Act, subject to the confidentiality provisions of Section 52 of The Act.



College and Association of Respiratory Therapists of Alberta

Suite #370, 6715 - 8<sup>th</sup> Street N.E., Calgary, Alberta, Canada T2E 7H7

Telephone (403) 274-1828 Fax (403) 274-9703 1-800-205-2778

APPLICATION FOR REGISTRATION AS A REGISTERED RESPIRATORY THERAPIST

Supplemental Comments:

Identify any practice specialties: \_\_\_\_\_

\_\_\_\_\_

Language spoken other than English: \_\_\_\_\_

\_\_\_\_\_

If registered in any other regulatory body, please identify which one: \_\_\_\_\_

\_\_\_\_\_

- I have a minimum of \$2,000,000.00 (two million dollars) liability insurance coverage as per CARTA Council policy
- My employer has a minimum of \$2,000,000.00 (two million dollars) liability insurance coverage as per CARTA Council policy

I **declare** that I have **read, understand and agree** to adhere to the Bylaws, Code of Ethics, Standards of Practice, and all legislation pertaining to Registered Respiratory Therapists in Alberta. Furthermore, I **declare** that all information provided is **accurate and true**.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_



College and Association of Respiratory Therapists of Alberta  
 Suite #370, 6715 – 8<sup>th</sup> Street N.E., Calgary, Alberta, Canada T2E 7H7  
 Telephone (403) 274-1828 Fax (403) 274-9703 1-800-205-2778  
**APPLICATION FOR REGISTRATION AS A  
 REGISTERED RESPIRATORY THERAPIST**

**Note:** Please ensure you have included the items below that apply to your application. The College cannot proceed with registration until all required documentation is received.

Application Requirements(s)	Graduate Class Provisional Register	General Class Register	General Register under the Mutual Recognition Agreement	Diagnostic Assessment Program Equivalency Review
<b>Application Form</b>	Yes	Yes	Yes	Yes
<b>Application Fee</b>	Yes	Yes	Yes	Yes
<b>Registration Fee</b>	Yes	Yes	Yes	(not required at the time of initial application)
Documentation verifying your <b>Citizenship Status</b> , permanent residency status (photocopy)	Yes	Yes	Yes	Yes
<b>Proof of Language Proficiency</b> (if your first language is neither English nor French and your respiratory therapy training was not in English or French)	Yes	Yes	Yes	Yes
<b>Employment History</b> (if you have been working in Respiratory Therapy)	Yes	Yes	Yes	Yes
Evidence of successful completion of your education program ( <b>transcripts</b> )	Yes	Yes		
Evidence of successful completion of the <b>approved examinations</b>		Yes		Yes
<b>Registration Verification Form</b> (If you have been registered as a Respiratory Therapist in another jurisdiction, or in any other health profession.	Yes	Yes	Yes	
Evidence of current <b>membership registration</b> with the other regulatory organizations (s)			Yes (see above)	
Evidence of (minimum) 720 hours of <b>active practice</b>			Yes	

The information collected on this form is for purpose of application of Part 2 of the *Health Professions Act*, subject to the confidentiality provisions of Section 52 of *The Act*.

The information collected on this form is for purpose of application of Part 2 of the *Health Professions Act*, subject to the confidentiality provisions of Section 52 of *The Act*.



College and Association of Respiratory Therapists of Alberta  
 Suite #370, 6715 – 8<sup>th</sup> Street N.E., Calgary, Alberta, Canada T2E 7H7  
 Telephone (403) 274-1828 Fax (403) 274-9703 1-800-205-2778  
**REGISTERED RESPIRATORY THERAPIST**  
**FEE SCHEDULE**

**FEES ARE ESTABLISHED PURSUANT TO THE BY- LAWS OF THE COLLEGE AND ASSOCIATION OF RESPIRATORY THERAPISTS OF ALBERTA AND ARE NON-REFUNDABLE. COUNCIL ESTABLISHES AND REVIEWS THIS FEE SCHEDULE ANNUALLY.**

**THE REGISTRATION YEAR IS APRIL 1<sup>ST</sup> TO MARCH 31<sup>ST</sup>**

Application Fee For Experienced Applicants	Registration Fee For Experienced Applicants	Renewal Fee	Duplicate Receipt/Permit Fee	NSF Cheque Fee
\$50.00	\$425.00	\$425.00	\$5.00	\$35.00
Application Fee For New Grads	Registration Fee For New Grads	Renewal Fee	Duplicate Receipt/Permit Fee	NSF Cheque Fee
\$50.00	\$225.00	\$425.00	\$5.00	\$35.00

**FEES PRO-RATED NOVEMBER 1<sup>ST</sup> TO MARCH 31<sup>ST</sup>**

Application Fee For Experienced Applicants	Registration Fee	Renewal Fee	Duplicate Receipt/Permit Fee	NSF Cheque Fee
\$50.00	\$212.50	\$212.50	\$5.00	\$35.00
Application Fee For New Grads	Registration Fee	Renewal Fee	Duplicate Receipt/Permit Fee	NSF Cheque Fee
\$50.00	\$112.50	\$112.50	\$5.00	\$35.00

The information collected on this form is for purpose of application of Part 2 of the *Health Professions Act*, subject to the confidentiality provisions of Section 52 of *The Act*.

**PLEASE INDICATE METHOD OF PAYMENT FOR FEE REMITTANCE:**

_____ Visa	_____	_____	_____
	Credit Card Number	Expiration Date	Fee
_____ Master Card	_____	_____	_____
	Credit Card Number	Expiration Date	Fee
_____ Cheque	_____		_____
			Fee
_____ Money Order	_____		_____
			Fee

**Cardholder will pay to the issuer of the charge card presented herewith the amount stated hereon in accordance with the issuer's agreement with the cardholder.**

\_\_\_\_\_ **Signature of Applicant** \_\_\_\_\_ **Date**

The information collected on this form is for purpose of application of Part 2 of the *Health Professions Act*, subject to the confidentiality provisions of Section 52 of *The Act*.

**The information collected on this form is for purpose of application of Part 2 of the *Health Professions Act*, subject to the confidentiality provisions of Section 52 of *The Act*.**