CANADIAN ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS

ASSOCIATION CANADIENNE DES TECHNOLOGUES EN RADIATION MÉDICALE

APPLICATION FOR REINSTATEMENT

NAME: Mr. / Mrs. / Ms. / Miss (Surname/Given)	Former Name/Nee	CAMRT Registration Number
Address	City & Postal Code	

Telephone

Home ____________ Fax ____________ E-mail ____________

Work ____________ Fax ____________ E-mail ____________

Date of Birth Year/ ____________ Month/ ____________ Date/ ____________

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

EMPLOYMENT INFORMATION (past 5 years)

Please include **"PROOF OF COMPETENCY"** if Non-Membership status is more than Five (5) years

Dates (from-to)	Institution	City	Mgr/Chief

Have you been employed on a part time/casual basis since the most recent date above? Yes ☐ No ☒

Enclosed is the administrative fee of $ ____________ and/or current membership dues of $ (To be forwarded from PMA)

Date ____________ Signature ____________

Provincial Association Use Only

Full Practice ☐	Non-practising ☐	Commercial Representative ☐
Last Paid Dues? ____________	Resigned in Good Standing? ☐	Membership in Arrears ☐

I hereby verify that this applicant DOES _______/ DOES NOT _____ meet the reinstatement requirements.

Date ____________ Association NAMRT Secretary - Treasurer Signature ____________

For CAMRT Use Only

Date received ____________ Date Approved ____________ Initial ____________