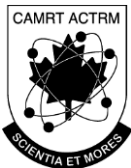


## APPLICATION FOR REINSTATEMENT



**PLEASE SUBMIT ALL PAYMENTS TO: NBAMRT REGISTRAR**  
**c/o NEW BRUNSWICK ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS**  
 489, ave Acadie Ave, Suite 205/unité 205, Dieppe NB E1A 1H7



<b>NAME:</b> Mr. / Mrs. / Ms. / Miss (Surname/Given)	<b>Former Name/Nee</b>	<b>CAMRT #</b>
<b>Address</b>	<b>City &amp; Postal Code&gt;</b>	

<b>Telephone: Home:</b> _____	<b>E-mail:</b> _____
<b>Work:</b> _____	<b>E-mail:</b> _____

**Date of Birth**    Year/                  Month/                  Day/ \_\_\_\_\_

Radiological Technologist <input type="checkbox"/>	Radiation Therapy <input type="checkbox"/>	Nuclear Medicine <input type="checkbox"/>	Magnetic Resonance <input type="checkbox"/>
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**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

Any current disciplinary action?                  Yes     No     If yes, please use the reverse side of the form to explain

Any complaint of Professional Misconduct against you?    Yes     No     If yes, please use the reverse side of the form to explain

**NBAMRT/CAMRT**

Enclosed is the administrative fee of \$ **25.00 (NBAMRT)** + current membership dues of \$ \_\_\_\_\_                  TOTAL: \$ \_\_\_\_\_

**Method of Payment:**    Cheque or Money order.

Date \_\_\_\_\_                  Signature \_\_\_\_\_

**NBAMRT Use Only**

Last Paid Dues?	Resigned? <input type="checkbox"/>	Membership Lapsed? <input type="checkbox"/>
Date Rec'd from Applicant:	Date of Cheque/Payment:	Date Sent to CAMRT:

We hereby verify that this applicant HAS fulfilled the requirements for reinstatement and the NBAMRT does recommend them for reinstatement

Date: \_\_\_\_\_                  Signature: \_\_\_\_\_

**For CAMRT Use Only**

Date received	Date Approved	Initial
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