College of Occupational Therapists of Nova Scotia
7001 Mumford Road, Halifax Shopping Centre, Box 11, HALIFAX, NS B3L 2H8

AUTHORIZATION FOR RELEASE OF INFORMATION

Applicant's Name:	**License #**
Applicant's Address:	
Applicant's Signature:	**Date:**
Witness' Signature:	**Date:**

I am applying for registration to practice as an occupational therapist in the province of Nova Scotia. The College of Occupational Therapists of Nova Scotia requires verification of registration from each province/jurisdiction wherein I hold or have held a licence or have been registered. This is your authority to release any information in your files, favourable or otherwise, directly to the College of Occupational Therapists of Nova Scotia at the address indicated above.

Within the past ten (10) years, has this person ever been licensed or registered to practice occupational therapy in your jurisdiction? No Yes

Dates: _____
_____

Are or were there any conditions/restrictions to his/her licence or registration to occupational therapy in your jurisdiction? No Yes
If yes, please describe: _____

_____

Has this person been the subject of any disciplinary action by your organization within the past five (5) years? No Yes
If yes, please describe the finding(s) and the penalty: _____

_____

Is there any reason why this person would not be entitled to be licensed or registered in your jurisdiction at the present time? No Yes
If yes, please explain: _____

_____

_____
Date

_____
Name of Registrar (Please print)

_____
Signature of Registrar or Designate

_____
Name and Address of Regulatory Board

Please Affix Seal

_____