

Document Request Form



CAPR
Canadian Alliance
of Physiotherapy
Regulators

ACORP
Alliance canadienne des
organismes de réglementation
de la physiothérapie

Instructions to Applicants:

1. Complete Section 1 of the Document Request Form.
2. Send the form to your school/institution to complete. Your school/institution must send the completed form directly to:

The Canadian Alliance of Physiotherapy Regulators
1243 Islington Avenue, Suite 501
Toronto, ON CANADA M8X 1Y9

For information about the application process and other required documents please review the **Required Documents List.**

If you have any questions please contact us at credentialling@alliancept.org.

Important Note:

Your **school/institution must be listed as the sender on all envelopes and packaging sent to our office.** If it is not sent directly to our office from your school/institution, **we will not accept the documents** and you will be required to have them resubmitted.



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Section 1: Applicant to complete before submitting to educational institution

First Name: _____

Middle Name: _____

Last Name: _____

Former Last Name (if applicable): _____

Date of Birth: Month/Day/Year _____

CAPR Client ID# (if known): _____

I hereby authorize the release of my educational records to the Canadian Alliance of Physiotherapy Regulators (CAPR).

Applicant signature

Date

Instructions to Educational Institution:

1. The Registrar, Controller of Examinations, or other authorized official such as a Principal, Dean or Head of Department must complete Section 2 of this form.
2. Place the completed form in an envelope, ensuring the institution stamps and seals are on the envelope and the institution is listed as the sender of the package, including courier packages.
3. Send the sealed envelope to CAPR. **Do not send this document to the student. We will not accept the documents from the student.**
4. Please do not use digital or electronic signatures, or digital or electronic seals/stamps on this document. We require you to complete this form using your original signature and original stamp and/or seal where specified on the form.



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Section 2: **Educational institution to complete before submitting to the Canadian Alliance of Physiotherapy Regulators (CAPR)**

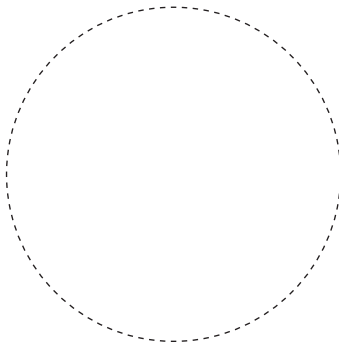
Name of person completing this form (print): _____

Job title of person completing this form: _____

Date Month/Day/Year: _____

Signature _____

School Seal/Stamp



Name of school/educational institution: _____

Institution Address: _____

Telephone: _____

Email: _____



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Student Information:

Student name: _____

Student date of birth: Month/Day/Year _____

Name of degree, diploma, or certificate awarded: _____

Dates of attendance: From: Month/Day/Year _____ To: Month/Day/Year _____

Date degree, diploma, or certificate was issued to the student: _____

Did the student transfer to this program from another institution? Yes ☐ No ☐

If yes, what institution did they transfer from? _____

Program Information:

What is the name of the authority legally entitled to accredit your institution?

Does this program prepare students for entry-level physiotherapy practice in your country?

Yes ☐ No ☐

Can the student work as a physiotherapist immediately following graduation?

Yes ☐ No ☐

If no, what other requirements must the student meet to be able to work as a physiotherapist?

For example, are there requirements such as a national exam, internship period, or registration with a regulatory body or Ministry of Health? Please provide as much information as possible.



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Supervised Clinical Practice:

Definition: Supervised clinical practice consists of supervised and evaluated experience as a physiotherapist-in-training within an entry-to-practice program, where the student gains practical experience and engages in a range of professional opportunities in various settings, for the purpose of learning and applying physiotherapy knowledge, skills, behaviours and clinical reasoning. Supervised clinical practice does not include academic classroom hours or practice on other students or staff.

Please complete the following sections (including the chart). Include the locations, dates, areas of practice, and hours the student completed during each clinical placement as part of the program. All fields must be completed.

Total hours of supervised clinical practice completed during the program:

LOCATIONS Include the full name of hospital/clinic	DATES Start to End	HOURS IN Musculoskeletal Conditions	HOURS IN Neurological Conditions	HOURS IN Cardiorespiratory Conditions	HOURS IN Other Conditions	TOTAL Hours



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