



CAPR
Canadian Alliance
of Physiotherapy
Regulators

ACORP
Alliance canadienne des
organismes de réglementation
de la physiothérapie

1243 Islington Avenue, Suite 501
Toronto, Ontario M8X 1Y9
P: 416 234 8800 | F: 416 234 8820
www.alliancept.org

Request for Academic Documents Form

Instructions for Applicant

- 1) Please complete the top part of the form.
- 2) Submit this form to the institution's **Registrar, Controller of Examinations, or other authorized school official.**

APPLICANT FULL NAME:

First Name: _____

Middle Name: _____

Last Name: _____

Former Last Name (if applicable): _____

Date of Birth: _____ 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 for Institution

The student named above has applied to CAPR for an educational credential and qualifications assessment. To help us complete the student's assessment, please provide the information requested below.

1. The Registrar, Controller of Examinations, or other authorized official such as a Principal, Dean or Head of Department must complete this form.
2. Place the completed form and other required documents in an envelope, ensuring the institution stamps and seals are on the envelope and that the institution is listed as the sender of the package, including courier packages. For information about required documents please see the [Required Documents List](#).
3. 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.
4. Send the sealed envelope to CAPR. **Do not send this document to the student. We will not accept the documents from the student.**
5. Send the form directly to:

The Canadian Alliance of Physiotherapy Regulators
1243 Islington Avenue, Suite 501
Toronto, ON CANADA M8X1Y9



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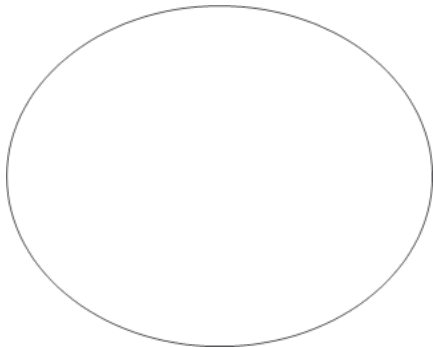
Educational institution to complete before submitting to the Canadian Alliance of Physiotherapy Regulators (CAPR)

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: _____

Name of degree, diploma, or certificate awarded: _____

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