Certification of Three Month Clinical Experience

College of Chiropodists of Ontario

This information is requested pursuant to s.4(1) 3 of the Registration Regulation O.Reg. 830/93

SECTION I:

To be completed by applicant and forwarded to the school of chiropody/podiatry, clinic, hospital or a practising registered chiropodist/podiatrist who can validate the applicant's clinical experience.

SURNAME	GIVEN NAME(s)	FORMER NAME(s)
ADDRESS		

CITY	PROVINCE	POSTAL CODE	COUNTRY	TELEPHONE

GRADUATED FROM (name and address of applicant's school of chiropody/podiatry)	
GRADUATION DATE (dd/mm/yy)	DEGREE/DIPLOMA OBTAINED

SECTION II:

To be completed by the registered practitioner and forwarded directly to the College of Chiropodists of Ontario.

I _____ certify that
(Given Name) (Surname)

_____ has completed three months
(Applicant's Given Name) (Surname)

clinical experience/internship in the period from _____ to _____ and demonstrated competent
(dd/mm/yy) (dd/mm/yy)

practice in chiropody/podiatry.

SIGNATURE: _____ DATE: _____

POSITION: _____ TELEPHONE: _____

NAME OF INSTITUTION / PRACTICE: _____

ADDRESS: _____

_____

FAX NUMBER: _____ EMAIL: _____

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