

Continuing Professional Competencies Program Resumption of Practice Application



MEMBER INFORMATION	
Name:	Certificate No:
Mailing Address:	
City:	
Country:	Postal Code:
Email:	
Tel:	Fax:
Employer Name:	
Supervisor and Contact info:	
COMMENTS (reasons or Circumstances that you declared yourself as “Non-Practicing”) Please also provide date declared “Non-practicing”.	

Applicant's Signature _____ Date _____

This request to Resume Active Practice has been reviewed by CoPE and has been

- Approved**
- Not Approved**

CoPE Representative _____ Date _____

CoPE shall keep all information provided on this application in confidence.