FORM 6 Application For Reinstatement
(sections 53-55)

COLLEGE OF CHIROPRACTORS OF BRITISH COLUMBIA
APPLICATION FOR REINSTATEMENT

A summary of the requirements for reinstatement is provided in the attached "Application for Reinstatement Information Form".

All required documentation must be received before your application will be processed.

Please type or print clearly: The name and address stated below will be used to advise you on all matters related to this application.

1. Personal Information

Name: _____
(Surname) *(First)* *(Middle)*

Birth date: *(mm/dd/yyyy)*_____ Maiden name: _____

Address: _____
(Number & Street) *(City)*

_____
(Province/State) *(Country)* *(Postal / Zip code)*

Phone: *(Daytime)* _____Phone: *(Evening)* _____

2. Reinstatement Category

I am applying for reinstatement:

(a) within 2 months of a failure to pay my registration renewal fee ☐

(b) after my registration has been expired for longer than 2 months but less than 3 years ☐

(c) after my registration has been expired for 3 years or longer ☐

(d) following disciplinary action ☐

Signature of Applicant: _____

Date of Signature: _____