



Mission Statement

Public confidence in receiving safe, competent, and ethical diagnostic and therapeutic care from regulated professionals.

Upgrading Application

Section 1: Applicant Information		
Legal last name	Legal given name(s)	Date of birth (DD/MM/YYYY)
Previous last name (if applicable)	Practice name (if different from legal name)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X
Home address	City/Province/Country	Postal code
Email		Telephone
Section 2: Specialty		
Specialty applying to upgrade		
Last year of employment in specialty	Total years employed in specialty	
Section 3: Educational Information		
Name of institution	Name of training program	
Program start date	Program completion date	
Section 4: Fees		
<input type="checkbox"/> \$100 application fee* Total fee: _____ Once the College has received your application, you will be instructed how to pay your fees online. Identify how you want to pay your fees by choosing one of the following options: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa Debit <input type="checkbox"/> Debit Mastercard <input type="checkbox"/> Cheque (Made payable to the ACMDTT)		
<small>*The upgrading application requires the payment of a one-time, non-refundable amount of \$100. Should you continue to the clinical portion of the upgrading program, this fee will be assessed against the fees associated with the required temporary practice application.</small>		

Email, fax or mail the completed form to the College:

info@acmdtt.com | T: 780.487.6130 | TF: 1.800.282.2165 | F: 780.432.9106 | Suite 800, 4445 Calgary Trail Edmonton AB T6H 5R7

Section 5: Applicant's Declaration

- I consent to the College disclosing my education, professional experience and entry-to-practice examination certification to the applicable post-secondary institution for the purpose of processing this application.
- I understand that the collection, use and disclosure of my personal information will be handled in accordance with the College's Privacy Policy.
- I understand that I am responsible for securing a site for the clinical component of the upgrading program.
- I verify that all statements contained in this application are accurate. I understand that a false or misleading statement, an omission or misrepresentation may be cause for cancellation of my practice permit and registration.
- I agree to notify the College immediately of any change to the information I have provided in accordance with College regulations under the *Health Professions Act* (i.e., employer and personal contact information).
- I understand that I cannot use the protected titles (i.e., MRT(R), MRT(NM), MRT(MR), MRT(T), ENP) or practice with the title of medical radiation technologist in Alberta if I do not hold a temporary or general practice permit issued by the College.
- I understand that I must hold a general or temporary practice permit issued by the College prior to practicing the profession in Alberta. Practice involves not only the clinical and technical aspects of the profession; it also includes, but is not limited to, functions of education, management, research, administration, and supervision.
- I understand that it is unlawful to practice in Alberta without registration from the College. The HPA clearly stipulates that in order to practice the profession, I must be registered with the College. If I do not register prior to practicing, it constitutes an offence, which is up to a fine of \$2,000 for the first offence.

Applicant's signature _____ **Date (DD/MM/YYYY)** _____

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