EBNMP™ Canada Association

Mailing Address: 20 Graydon Hall Drive, Suite 104, North York, ON M3A 2Z9
Phone (416) 335-7661 admin@ebnmp.com www.ebnmp.com

Renewal Form

Please PRINT or TYPE all requested information

Name					
Address					
City		Province		Postal Code	
Tel. Home		Tel. Office			
Fax		Cell			
Company					
Email		Website			

Requirements for Renewal of Registration

O DNM®	DNM® # ____________________	Fee Amount __________________
O Registered Practitioner	_________ # ____________________	Fee Amount __________________
O Retired / Not currently in practice (contact us for fee) $__________ (Please fill in quoted amount)		
O Proof of Professional Liability Insurance		
O Proof of CCE (DNM® 60 hrs, Level II Practitioners 40 hrs, Level I Practitioners 30 hrs)		
O Please enclose photocopies of new certificates, diplomas, etc. or updated C.V.		
O Please enclose a passport sized photo for your member ID card. (Can also be sent via email)		
O Payment must be in the form of cheque / money order payable to EBNMP™ Canada. (Credit card authorization on back of form)		

Read the following statements, sign & date.
Submit this form along with the required fee and documents.

- ✓ I have successfully completed the CCE courses as indicated on the enclosed documents.
- ✓ I understand the designation that I am renewing is owned by WBNM and **must be renewed annually** to validate my position on the registry with EBNMP™ Canada Association.
- ✓ I understand that EBNMP™ Canada Association is licensing the requested designation to me to identify the services which meet the standards as set by EBNMP™ Canada Association and must be surrendered when registration ceases or at the request of the Disciplinary Committee of EBNMP™ Canada Association.
- ✓ I certify that the above information is correct to the best of my knowledge.
- ✓ I have enclosed a cheque / money order payable to EBNMP™ Canada Association for the renewal of my designation.

______________________________ ______________________________
Date of Renewal Signature of Practitioner

For Office Use Only

Date Rec'd:		Pymt Amt:		Pymt Type:	
Date of Pymt:		Name on Pymt:			
Bank / CC:					

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CREDIT CARD AUTHORIZATION

Please note: Payments are processed through “Natural Medicine Institutes”. ($10 processing fee applies.)

Credit Card #:		Expiry Date:		Security Code:	
Cardholder:					
Address:					
City, Postal Code:		Amount:	(plus $10 processing fee)		
Signature:		I Agree to Pay Above Total Amount (including processing fee) According to Card Issuer Agreement.			

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