

The Promotional Services You Need:

Site	Selected (√)
CanadianNaturopaths.com main listing	Yes
Specialty Site: Asian Medicine	
Specialty Site: IV Treatment	
Specialty Site: Botanical Medicine	
Specialty Site: Clinical Nutrition	

The Billing Process & Plan You Requested:

365 Annual Plan (Pay for 10 months, 2 months free) _____

Monthly Plan (Pay month by month, no free months) _____

Invoice (Available for 365 Only) : _____ OR

Credit Card#

Expiry

Name on the card

Personal Information:

Name

Phone

Email – for administrative contact – i.e. billing

November 11, 2007

**CanadianNaturopaths.com Registration Form
Fax Completed Form to 416 249 8696**

Your Clinic Details:

Clinic Name

Postal Code

Clinic Address

Clinic City

Clinic Website

Clinic Email Address

Information for Your Personal Biographical Page:

You may submit a freeform biographical summary (3-5 paragraphs) if you wish (Please use the attached page for this purpose) In addition, please complete the following checklists:

Your Qualifications:

Languages spoken:

(Check all applicable√)

<input checked="" type="checkbox"/>	English
<input type="checkbox"/>	French
<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Cantonese
<input type="checkbox"/>	Other (Specify: _____)

Professional Degrees:

School/University	Degree
	Doctor of Naturopathic Medicine
	Other: Specify: _____
	Other: Specify: _____

Professional Associations: (Check all that are applicable)

Association	Member (✓)
<i>Canadian Association of Naturopathic Doctors (CAND)</i>	
<i>Ontario Association of Naturopathic Doctors</i>	
<i>British Columbia Naturopathic Association (BCNA)</i>	
<i>Alberta Association of Naturopathic Practitioners (AANP)</i>	
<i>Saskatchewan Association of Naturopathic Practitioners (SANP)</i>	
<i>Nova Scotia Association of Naturopathic Doctors (NSAND)</i>	
<i>New Brunswick Association of Naturopathic Doctors (NBAND)</i>	
<i>Manitoba Naturopathic Association (MNA)</i>	
<i>Other Specify:</i>	

Additional Certifications:

Please specify.

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Specialties: (Check all that are appropriate)

<input checked="" type="checkbox"/>	Women's Health	<input type="checkbox"/>	Men's Health	<input checked="" type="checkbox"/>	Addiction	<input type="checkbox"/>
	Allergies/Asthma		Anti-aging		Arthritis	
	Back Pain/Problems		Blood Pressure/Cholesterol		Cancer	
	Depression/Anxiety		Diabetes		Diet & Nutrition	
	Digestive Problems		HIV/AIDS		Pain Management	
	Mental health		Neurological		Pregnancy/Pediatrics	
	Sleep Disorders		Stress		Sexual Dysfunction or infertility	
	Skin problems		Weight Loss			
	Other (specify)					
	Other (specify)					

Treatment Options & Preferences: (Check all that are appropriate)

<input type="checkbox"/>	Asian Medicine incl acupuncture	<input checked="" type="checkbox"/>	Botanical Medicine	<input type="checkbox"/>
	Bowen Treatment		Chelation	
	Clinical Nutrition		Cosmetic Acupuncture	
	Counseling/Life Style Management		Detoxification	
	Homeopathy		Intravenous (IV) Treatment	
	Massage		Myofascial Trigger Point Release	
	Sports Medicine			
	Other (specify)		Other(specify)	

Free-form Biographical Page Summary:

(This page, while optional, is highly recommended. If you need extra time to compose your biographical information, please fax the first 4 pages as soon as possible. This page can be sent at your convenience.)