

Applications submitted without all of the required supporting documentation will not be processed. Please allow 6 weeks for processing.

**Application for External Candidates**

**Regulation has been introduced in Ontario. (Selection required.)**

Do you plan on seeking employment in Ontario?  Yes  No  
 Do you plan on seeking employment in Alberta?  Yes  No

**1. PERSONAL AND CONTACT INFORMATION (PLEASE TYPE OR PRINT LEGIBLY.)**

<b>First Name</b>	<b>Last Name</b>
<b>Middle Name / Initial</b>	<b>Sonography Canada No. (if applicable)</b>
<b>Date of Birth:</b> _____ (D/M/YR)	<b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/>
<b>Address (Line 1)</b>	<b>Address (Line 2) (indicate Apt. / Unit #)</b>
<b>P.O. Box or Rural Route (if applicable)</b>	<b>City</b>
<b>Province</b> <b>Postal Code</b>	<b>Country</b>
(____) _____ <b>Telephone Number</b>	<b>E-Mail Address (mandatory)</b>

**2. CURRENT EMPLOYMENT STATUS (PLEASE PRINT OR TYPE LEGIBLY)**

Are you currently employed?  Yes     No

If yes, please complete the section below providing complete information about your current employment:

<b>Name of Employer (if employed)</b>	<b>Name of Supervisor</b>
(____) _____ <b>Work Telephone Number</b>	<b>Supervisor's email Address</b>
<b>Address (Line 1)</b>	<b>Address (Line 2)</b>
<b>P.O. Box or Rural Route (if applicable)</b>	<b>City</b>
<b>Province</b> <b>Postal Code</b>	<b>Country</b>

<b>3. Indicate the credential(s) for which you are applying:</b>	
<input type="checkbox"/> CRGS®	<b>Canadian Registered Generalist Sonographer</b>
<input type="checkbox"/> CRCS®	<b>Canadian Registered Cardiac Sonographer</b>
<input type="checkbox"/> CRVS®	<b>Canadian Registered Vascular Sonographer</b>

<b>4. REQUIRED SUPPORTING DOCUMENTATION</b>	
<b>A. PROOF OF FORMAL DIAGNOSTIC ULTRASOUND EDUCATION:</b>	

<b>Have you graduated from a Sonography Canada approved Accreditation Canada (AC) accredited program in Diagnostic Medical Sonography?</b> (minimum 12 months didactic and clinical education)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Have you graduated from a non-accredited formal education program in Diagnostic Medical Sonography?</b> (minimum 12 months didactic and clinical education) <i>If your education was not from a sonography specific program, please expand on the program's sonography content (didactic and clinical), any on the job training, or independent learning in the field in your work resume or separate document.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Indicate the supporting documentation that you have enclosed:</b> <input type="checkbox"/> Notarized copy of your graduation degree / diploma / certificate (required) <input type="checkbox"/> Copy of your Official Final Transcript (required) <input type="checkbox"/> Please identify any additional education program documentation that you are sending: _____	
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<b>Indicate Degree / Diploma / Certificate obtained:</b> _____	<b>Indicate date of graduation:</b> _____ Day / Month / Year
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<b>B. WORK RESUME</b>	
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<b>Have you attached a current resume outlining your diagnostic ultrasound education and work experience?</b> <i>Resume should include a list of all positions held including name of employer and contact information, time period worked and work responsibilities during the employment.</i> (Minimum 5 years of experience as a practicing sonographer)	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>C. LETTER FROM EMPLOYER</b>	
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<b>Have you attached an original signed letter on business letterhead from your current employer?</b> <i>This letter should indicate the following: your level of clinical competency, your position, work responsibilities, types of examinations performed, approximate number of patients scanned per day, and years of ultrasound examination experience at site.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>D. NATIONAL CERTIFICATION:</b>	
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<b>Have you successfully passed a national certification examination(s) and have you enclosed proof of this current certification(s)? (e.g. ARDMS,)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please indicate which Certification(s) you currently hold? \_\_\_\_\_

<b>5. Method of Correspondence for Processing this Application Form</b>	
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<b>Please indicate your preferred method of correspondence to process this application?</b>	<input type="checkbox"/> Mail <input type="checkbox"/> Email
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6. ACKNOWLEDGMENT AND STATEMENT OF AGREEMENT	
<input type="checkbox"/>	I hereby certify that the information contained herein is true and accurate to the best of my knowledge.
<input type="checkbox"/>	I have been made aware of the credentialing requirements and I agree to abide by the rules and regulations of the application process for Sonography Canada Membership for practicing and externally-trained candidates as outlined by Sonography Canada. I have read and understand all of the terms and conditions regarding this application process, as made available on the Sonography Canada website. I am fully compliant with, and I agree to abide by all of terms and conditions therein. I understand that Sonography Canada reserves the right to deny my application; revoke my eligibility as a candidate; or take action against me in my capacity as a Registrant if the documentation I provide is found to be fraudulent or a misrepresentation of the facts.
<input type="checkbox"/>	I acknowledge that Sonography Canada may disclose to third parties my personal information contained herein (in whole or in part) for the purpose of verifying the accuracy thereof and for no other purpose. I consent to such disclosure provided that before disclosing any of my personal information to any third party for such purpose, Sonography Canada enters into an agreement with the third party pursuant to which it is required to use that information solely for the purpose of verifying the accuracy thereof and to maintain privacy measures at least as stringent as those of Sonography Canada.  I also consent to third parties disclosing my personal information to Sonography Canada, so that Sonography Canada can process my application and verify the accuracy of the information provided in this Application.
<input type="checkbox"/>	I have read and understand Sonography Canada's Privacy Policy and I consent to the collection, use and disclosure of my personal information for the purposes described in Sonography Canada's Privacy Policy.
<input type="checkbox"/>	I agree to comply with the Code of Ethics for the profession of Diagnostic Medical Sonography as outlined on the Sonography Canada website, and to comply with all other rules, regulations and policies pertaining to this Application and to the standards and renewal of any credential I may receive through Sonography Canada.
<input type="checkbox"/>	I acknowledge and agree that, while Sonography Canada takes reasonable steps to ensure the accuracy and completeness of its information, resources and reports, neither Sonography Canada nor any of its directors, officers, agents or employees shall be responsible for damages or losses in the event of any errors or omissions contained therein, nor shall Sonography Canada be liable for any damages or losses whatsoever (including without limitation damages of a personal, professional or financial nature) incurred by me as a result of any decision pertaining to this Application made by or on behalf of Sonography Canada or any of its directors, officers, agents or employees.  By completing a Sonography Canada Application for External candidates, I further agree that I shall not take any legal action or commence other proceedings against Sonography Canada or any of its directors, officers, agents and employees for anything done in good faith related to a Sonography Canada application for external candidates, including any errors, omissions, neglect or default in respect thereof.  I also agree to indemnify and hold harmless Sonography Canada and each of its directors, officers, agents and employees (the Indemnified Parties) absolutely and forever, from and against any and all claims, actions, damages, suits, liabilities, obligations, costs, fees, charges, and other expenses whatsoever, including reasonable legal fees and costs (collectively the "Claim"), that may be asserted against any Indemnified Party in connection with the information provided to an Indemnified Party by me hereunder and any error, omission or inaccuracy in respect thereof.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_  
Day / Month / Year

FOR SONOGRAPHY CANADA OFFICE USE ONLY	
Date received: _____ Day / Month / Year	Decision:    Approved _____ Rejected _____
If approved, recommended for:	<input type="checkbox"/> SONOGRAPHY CANADA Examination(s) <input type="checkbox"/> Generalist <input type="checkbox"/> Cardiac <input type="checkbox"/> Vascular  <input type="checkbox"/> Canadian Clinical Skills Assessment <input type="checkbox"/> Generalist <input type="checkbox"/> Cardiac <input type="checkbox"/> Vascular
If rejected, reason: _____ _____	

## 7. METHOD OF PAYMENT

The cost of processing and evaluating this application for registration including the review and verification of supporting documentation is a nonrefundable fee of \$100.00. (Other fees will apply for the written exams and the Canadian Clinical Skills Assessment (CCSA) Scan Test.)

**Amount:**

<b>Credit Card Number:</b>	<b>CVV:</b>	<b>Expiry Date:</b>	<u>    </u> / <u>    </u> / <u>    </u> M / Y
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<b>Name as it Appears on Credit Card:</b>	<b>Signature of Cardholder:</b>
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**PLEASE ENSURE THAT YOUR APPLICATION IS SIGNED AND DATED ON PAGE 3. PLEASE APPEND PHOTOCOPIES OF YOUR GRADUATION DEGREE / DIPLOMA / CERTIFICATE, ARDMS CERTIFICATION AND RESUME AS ALL DOCUMENTATION SUBMITTED BECOMES THE PROPERTY OF SONOGRAPHY CANADA AND WILL NOT BE RETURNED. DO NOT SEND ORIGINALS OF THESE DOCUMENTS. PLEASE ENSURE THAT THE FINAL OFFICIAL TRANSCRIPT AND LETTER FROM YOUR EMPLOYER ARE ORIGINALS AND ON OFFICIAL LETTERHEAD. THE LETTER FROM YOUR EMPLOYER MUST BE SIGNED.**

**MAIL THE COMPLETED APPLICATION, FEE PAYMENT AND THE REQUIRED SUPPORTING DOCUMENTATION TO SONOGRAPHY CANADA AT THE FOLLOWING ADDRESS:**

**SONOGRAPHY CANADA  
P.O. Box 1220  
KEMPTVILLE, ON K0G 1J0**

**IF SENDING BY COURIER, USE THE FOLLOWING ADDRESS:**

**SONOGRAPHY CANADA  
215 VAN BUREN ST., UNIT 2, LOWER LEVEL  
KEMPTVILLE, ON K0G 1J0**

**TEL: 613-258-0855  
TOLL FREE: 1-888-273-6746**

**PLEASE ENSURE THE MAILING AND EMAIL ADDRESS THAT YOU PROVIDE FOR COMMUNICATION IS CURRENT AND RELIABLE.**

## Generalist Exam Type Checklist

**Name:** \_\_\_\_\_

Please check off all exam types that you have been trained in and are able to competently perform.

<b>Exam Types</b>	<b>Specific Exams</b>	<b>Have performed within the last 12 months</b>	<b>Have performed within the last 3 years</b>	<b>Have the training, but have NOT performed within the last 3 years</b>
<b>Abdominal</b>	Abdomen			
	Renal			
	Aorta			
	Male pelvis			
	Prostate (transabdominal)			
<b>Superficial Structures</b>	Thyroid			
	Scrotum			
	Other superficial structures (Examples: Salivary glands, superficial tissues etc.)			
<b>Gynecological</b>	Transabdominal			
	Transvaginal			
<b>Obstetrical</b>	1 <sup>st</sup> Trimester			
	2 <sup>nd</sup> and 3 <sup>rd</sup> Trimester			
	Biophysical profile			
<b>Musculoskeletal (MSK)</b>	General MSK (Examples: Shoulder, knee, elbow etc.)			
<b>Vascular</b>	Extracranial Arteries			
	Peripheral Veins (lower extremity) for DVT			
	Peripheral Veins (upper extremity) for DVT			

Please list any additional exam types in which you are competent in and/or comments:

## Vascular Exam Type Checklist

Name: \_\_\_\_\_

Please check off all exam types that you have been trained in and are able to competently perform.

Exam Types	Specific Exams	Have performed within the last 12 months	Have performed within the last 3 years	Have the training, but have NOT performed within the last 3 years
<b>Abdominal Vascular</b>	Renal Artery Stenosis			
	Pre/Post Transplants			
	Portal Hypertension			
<b>Extracranial Arteries</b>	Carotid Arteries (including subclavian arteries)			
<b>Peripheral Arteries</b>				
<b>-Lower Extremity (Duplex Assessment)</b>	Graft Surveillance			
	Aorta / Iliac Arteries			
	Post Angioplasty Follow Up			
	Follow Up of Hemodynamically Significant Stenosis			
<b>-Lower Extremity (Physiologic Assessment)</b>	ABI/TBI			
	Segmental Pressures			
	Exercise Testing			
	Raynaud's Testing			
<b>Peripheral Veins</b>				
<b>-Lower Extremity</b>	DVT			
	Venous Insufficiency			
<b>Other examinations and/or comments:</b>				