

**Internationally Educated Diagnostic Medical Sonographer  
APPLICATION for ASSESSMENT**

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First Name  
Please print

Middle Name

Last Name

Previous surname

Birth date Day/Month/Year

M  F  
Sex

Mailing address:

Street name and number

City

Province / District

Country

Postal code

Telephone number (include country & area codes)

E-mail

Canadian province in which you intend to practice

**PART 1**  
**Education Program in DMS**

You must provide NSCMIRTP with evidence that you have successfully completed an educational program in DMS at a post-secondary school level.

Following is the evidence you must supply:

- Official transcript of marks, notarized copy
- Evidence of completion of program – diploma or degree certificate, notarized copy
- Curriculum or course outline indicating
  - Detailed list of courses and description of each

**Title of program completed** \_\_\_\_\_

**Name of diploma/degree** \_\_\_\_\_  
(As printed on the official graduation document)

**Education institution for theoretical instruction:** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Start date \_\_\_\_\_ Completion date \_\_\_\_\_  
Month / Year Month / Year

**Institution(s) for clinical training:** \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_

Start date \_\_\_\_\_ Completion date \_\_\_\_\_  
Month / Year Month / Year

If other institutions were used for clinical training, please provide the required information on another sheet of paper:

**Length of total program – theoretical in months:** \_\_\_\_\_ **clinical in months:** \_\_\_\_\_

Have you attended a Canadian DMS bridging program?  Yes  No

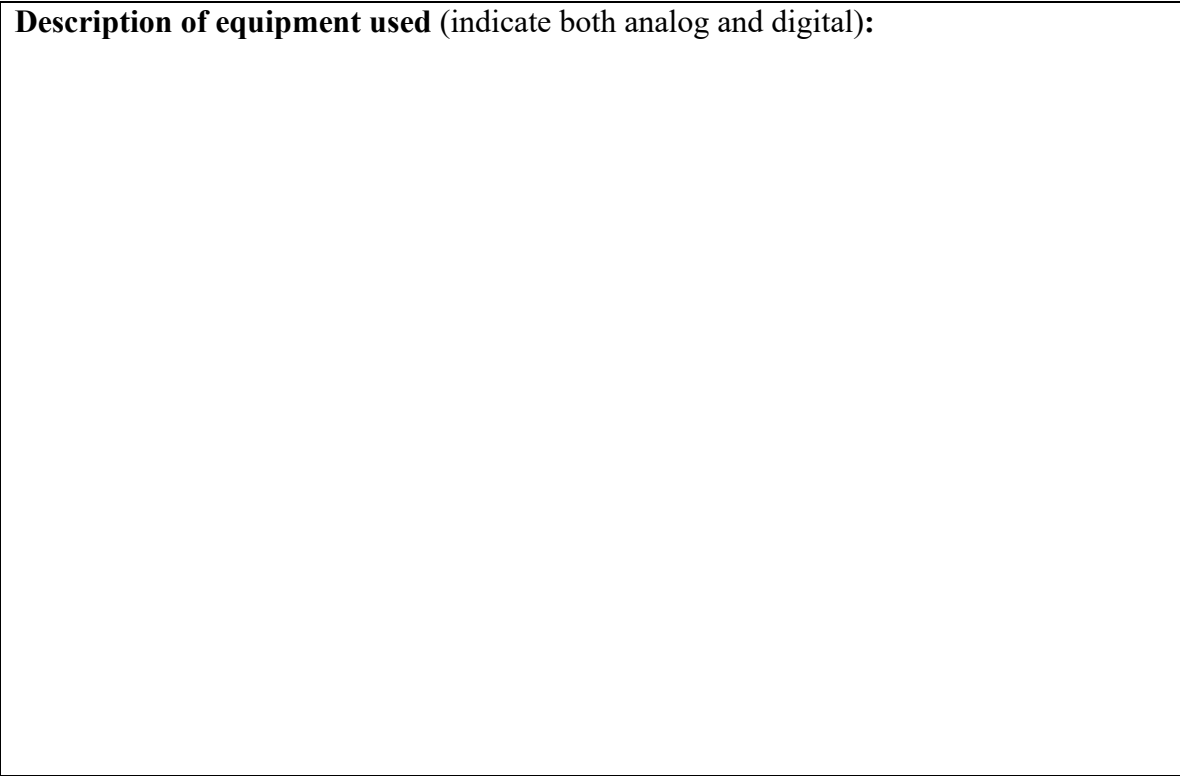
If yes, where? \_\_\_\_\_  
(Canadian educational institution, city, province)

**Description of education program**

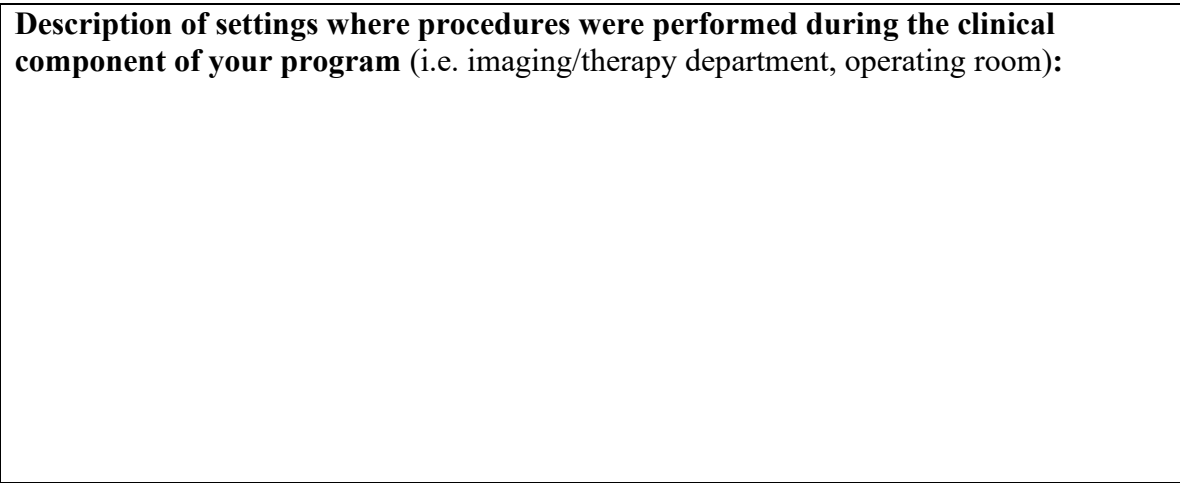
In addition to providing a detailed list of courses and a description of the content of each course, additional information on the educational program is required.

**Description of the clinical setting in your education program** (describe types of equipment used, settings where procedures were performed and types of patients):

**Description of equipment used** (indicate both analog and digital):



**Description of settings where procedures were performed during the clinical component of your program** (i.e. imaging/therapy department, operating room):



**Description of types of patients on whom procedures were performed (i.e. adult, pediatric, trauma):**

**PART 2  
Language Fluency**

You are required to provide evidence of language fluency in English if not your first language.

- Attach proof from your education institution that your program, both theoretical and clinical, were conducted in English.

OR

- Submit language fluency testing results - see NSCMIRTP's [language fluency policy](#) .

If English was not the language of instruction, what language was spoken?

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What language was used in your practice of DMS in the past five (5) years?

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**PART 3**  
**Work Experience**

Indicate the number of hours (based on 7.5-hour work day) worked in the preceding five (5) years in the discipline for which you are applying.

List the name, address, e-mail and telephone number of all employers within the last five (5) years and include the start date and finish date of employment.

Start date / Finish date Month / Year	Facility name	Address include city / country / contact information	Supervisor's name / signature

- Attach a letter of confirmation of employment and reference as a Sonographer from your last or current employer. The letter must be dated and confirm your **last date of employment**.
- Attach completed [Vascular Assessment Checklist](#) or [Generalist Assessment Checklist](#)
- Attach evidence of registration with an association / society / regulatory body for the specific discipline, if available.
- Attach relevant evidence of continued professional development activities in the discipline in which you are applying.

**PART 4**  
**Declaration of Conduct**

Attach one (1) letter of reference in support of good character from a person who has known you for the past two (2) years.

Have you been the subject of a finding of professional misconduct, incompetence or incapacity in relation to the DMS profession or another health profession?

- Yes                       No

Have you been convicted of a criminal offence or an offence related to the regulation of practice in DMS?

- Yes                       No

If you have answered “yes” to the questions above, please give details on a separate page.

**PART 5**  
**Declaration of Compliance and Checklist**

- ✓ I verify that all statements in this application are accurate. I understand that a false or misleading statement, omission or misrepresentation may compromise my registration request.
- ✓ I authorize NSCMIRTP to contact any authority, institution, association, body or person in any jurisdiction to verify the statements in my application and related documents.
- ✓ I understand that collection, use, and disclosure of my personal information will be handled in a confidential manner by the NSCMIRTP.
- ✓ I agree to notify NSCMIRTP of any changes in my contact information.
- ✓ I understand that I may be required to submit further information if required.

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**Signature of applicant**

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**Date (month/day/year)**

**Part 6**  
**Submission of Fees**

**Non-refundable assessment fee of \$300.00 CAD**

Payment by:

- Cheque (post-dated cheques are NOT accepted) or money order, payable to the NSCMIRTP.

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**Signature**

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**Date**

Following is a checklist of documents included for assessment:

- Completed assessment application form
- Assessment fee
- Notarized copies of official transcript of marks and certificate/diploma
- Course syllabus / description of courses
- Language proficiency documentation
- Letter of reference confirming employment and last date of practice
- Clinical assessment checklist for discipline
- Evidence of registration with professional association, if available
- Evidence of continued professional development, if available
- Letter of reference supporting good character

**Please send completed form and supporting documents to:**

**Nova Scotia College of Medical Imaging and Radiation Therapy  
Professionals (NSCMIRTP)**

**310-380 Bedford Highway,  
Bedford, NS, B3M 2L4  
CANADA**

**Phone: (902) 832-3167**

**E-mail : [info@nscmirtp.ca](mailto:info@nscmirtp.ca)**

**Website: [www.nscmirtp.ca](http://www.nscmirtp.ca)**