The College of Naturopaths of Ontario

The Inspection Program of the College of Naturopaths of Ontario inspects the premises where compounding for or the administration of IVIT are performed. In order to collect the relevant information needed to ensure all premises will be inspected a separate form must be submitted by the designated Registrant for every premises where these procedures are performed.

Information provided on this form must be complete and preferably typed into the necessary fields. If completing the form by hand please ensure it is legible. Submitting an incomplete or illegible form will result in it being returned, please carefully review the form and the information you have provided.

This form may be submitted in one of the following ways:

By email: inspections@collegeofnaturopaths.on.ca

By post: College of Naturopaths of Ontario
Inspection Department
150 John St, 10th Floor
Toronto, ON
M5V 3E3

By fax: 416-583-6011.

Registering a New IVIT Premises

1. IVIT Premises Address

Clinic Name:			
Street address:			
City:	Province:	Postal Code:	Fax number:
Telephone number:	Premises email address:		

2. Designated Registrant Information

The designated Registrant is the Naturopathic Doctor who has been identified as the Registrant who is authorized to deliver and accept information on behalf of the premises. If there is only one Naturopathic Doctor authorized to perform IVIT and compounding for IVIT in the premises then that Registrant is the designated Registrant. In a premises where more than one Naturopathic Doctor is authorized to perform IVIT and compounding for IVIT in the premises one of the Registrants must be identified as the designated Registrant.

Last Name:		First Name:	Middle Name:
Registration Number:	Email Address:		Phone Number:

3. Inspection Timeline

The College is required to conduct Part I of the inspection of a new premises within 180 days of the date this form is received by the College (Section 31(2) of the General Regulation). Please provide the date when you anticipate the premises will be ready to be inspected. The College will make every effort to inspect the premises within a reasonable time after the date you have provided, however the inspection may occur at any time within the 180 day period.

Date the premises will be prepared for an inspection: _______________
(mm/dd/yyyy)

4. IVIT Procedures Performed

Please check the appropriate box(es) to indicate the IVIT procedures that will be performed by Members at the above premises:

☐ Administering IVIT

☐ Compounding for IVIT

5. Delegation

Indicate which procedures are or may be delegated by Registrant to another staff member.

☐ administering by IVIT

☐ compounding for IVIT

List the procedures that are or may be delegated to a Registrant.

6. Premises Information

Name of the owner of the building where the premises is located:

Name of leaseholder of the premises (if applicable):

7. Health Profession Corporations

List the name(s) and registration number(s) of any health profession corporation(s) that will be administering IVIT or compounding for IVIT at the premises. For a naturopathic health professional corporation please ensure that the name and registration number are those that appear on the College's Professional Corporations Register. (If you require more room please attach a separate sheet.)

Corporation Name:	Registration Number:
Corporation Name:	Registration Number:
Corporation Name:	Registration Number:
Corporation Name:	Registration Number:
Corporation Name:	Registration Number:

8. Regulated Health Care Professionals Practicing in the Premises

List the name(s) of all **Naturopathic Doctors**, including the designated Registrant, who will be performing or may be performing compounding for or administration of IVIT at this premises. (If you require more room please attach a separate sheet.)

Last name:	First name:	Registration number:
Last name:	First name:	Registration number:
Last name:	First name:	Registration number:
Last name:	First name:	Registration number:
Last name:	First name:	Registration number:
Last name:	First name:	Registration number:

List the name(s) of any **other regulated health care professionals** who will be practising or may be practising IVIT procedures at the premises and the regulatory College where the professional is a Registrant. (If you require more room please attach a separate sheet.)

Last name:	First name:	College:	Registration number:
Last name:	First name:	College:	Registration number:
Last name:	First name:	College:	Registration number:

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Last name:	First name:	College:	Registration number:
Last name:	First name:	College:	Registration number:
Last name:	First name:	College:	Registration number:

9. Non-regulated Staff

List the name(s) of any **staff who are not regulated health care professionals** and who will be involved in providing some aspect of patient care related to the administration of IVIT or compounding for IVIT at the premises. Include information regarding the person's qualifications, credentials, training and responsibilities (If you require more room please attach a separate sheet.)

Last name:	First name:	Middle name:
Qualifications, Credentials, Training:		
Responsibilities:		
Last name:	First name:	Middle name:
Qualifications, Credentials, Training:		
Responsibilities:		
Last name:	First name:	Middle name:
Qualifications, Credentials, Training:		
Responsibilities:		

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10. Equipment and Materials

Provide a description of any equipment or materials that will be used in the performance of administering IVIT and compounding for IVIT. This may include but is not limited to the laminar air flow hood, needles, blood pressure monitor and pulse oximeter. (Attach a separate sheet if needed.)

11. Declaration and Signature

I hereby declare that, to the best of my knowledge, the information on this form is true and complete. I understand and agree that it is professional misconduct to make a false or misleading statement.

Name:	Signature:	Date:

☐ **Please check this box if you are completing this form electronically. This represents your signature.**

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