Canadian College of Naturopathic Medicine

** Please ensure these forms are returned to the RESIDENCE DEPARTMENT ONLY**

PERSONAL INFORMATION

Surname: _____ First Name: _____

Email Address: _____ Birthday (M/D/Y): _____

Cell Phone: _____

Requested Move- In Date (M/D/Y): _____ Move-Out Date (M/D/Y): _____

ACADEMIC INFORMATION / WORK INFORMATION

Institute Attending: _____

EMERGENCY CONTACT

Name of emergency contact: _____ Relationship: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ E-mail address: _____

This application must be completely filled out and submitted .

The undersigned agrees to abide and be bound by the terms and conditions set forth in the Student Residence Contract.

The information collected on this form is used solely by the administration of the Canadian College of Naturopathic Medicine.

Date (M/D/Y): _____ Signature: _____

Employee Signature: _____ Date: _____

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