Government of Newfoundland and Labrador
Department of Health and Community Services
Newfoundland and Labrador Paramedicine Regulation (NLPR)

Change of Personal Information Form

Please use either a laptop or personal computer in order to complete and submit this form electronically to NLPR. Phones or hand held devices may have software incompatibility. **Photographs of documentation is not accepted.**

Updated Information: *(please print)*

Surname:	First Name:	
Maiden Name: If Applicable	Gender:	Licence #:
Mailing Address:		
City/Town:	Province:	Postal Code:
Home Telephone #:	Cellular Telephone #:	
Email:		

FOR NAME CHANGE ONLY: *(Please check item submitted as legal proof of name change)*

☐ Driver's Licence ☐ Birth Certificate
☐ Marriage Certificate ☐ Divorce Decree

The personal information requested in this form is collected under the authority of section 61(a)(c) of the Access to Information and Protection of Privacy Act, 2015 for the purpose of regulation information with NLPR operated by the Department of Health and Community Services. If you have questions concerning the collection, use, and disclosure of your personal information, please contact the Department at healthinfo@gov.nl.ca.

Opt-in/Opt-out Consent:

The Canadian Anti-Spam Law (CASL) is part of federal legislation designed to reduce the amount of email delivered without the consent of the recipient. This legislation affects NLPR sending commercial electronic messages or emails that encourage participation in a commercial activity or transaction.

Please confirm your consent in receiving commercial electronic communications surrounding Paramedicine sent to NLPR for distribution.

☐ YES, I do give consent ☐ NO, I do not give consent

Paramedicine providers who choose to opt-out from receiving commercial electronic communications will continue to receive electronic notifications pertaining to their professional responsibilities as a provider with NLPR.

Provider Verification:

By signing this form as the provider, I acknowledge all the provided information listed above to be true:

Provider Signature: _____ Date: _____
(DD-MONTH-YYYY)