BOUCHER INSTITUTE
of Naturopathic Medicine

DR. PATRICIA WOLFE APPLICATION FORM

PERSONAL INFORMATION

First Name:	Last Name:		
Mailing Address:			
City:	Province:	Postal Code:	
Email address:			Cohort: ND

DECLARATION TO BE COMPLETED BY ALL APPLICANTS

I hereby declare that all information given above is complete and true to the best of my knowledge. I consent to the disclosure of information on this form to other educational institutions and the Student Services Branch of the Ministry of Advanced Education, Training and Technology when necessary to verify information. I understand failure to provide my consent or misrepresentation may result in cancellation of this application or the award I may receive. If granted an award, I understand that any debts I may have outstanding to Boucher Institute of Naturopathic Medicine will be deducted from the award.

Signature: _____ Date: _____

Freedom of information/protection of privacy: BINM complies with the Freedom of Information/Protection of Privacy legislation of the Province of British Columbia. Information collected on application forms is used in the normal course of operations in accordance with this legislation.