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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: \_\_\_\_\_

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EMERGENCY CONTACT

Name of emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

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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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