

**APPLICATION FOR  
SCHOOL PSYCHOLOGIST REGISTRATION**

<b>Applicant Name:</b>
<b>Date of Application</b> (year / month / day):
<b>Mailing Address:</b> Please inform the College in writing of any changes within 30 days.
<b>Phone Number and Email Address:</b> All formal notices and communication from the College will be sent to applicants by mail to the mailing address above. However, there are times where it is expeditious for the College to contact applicants by phone, fax or email. Phone number(s): _____ Fax number: _____ Email address: _____

**Please print in ink or type your information**

**Submitting documentation:** This Application Form includes an Enclosure Checklist. Please attach all required documents and return the completed Application Form, with attachments, to the College at the following address:

The Registrar  
College of Psychologists of British Columbia  
404-1755 West Broadway  
Vancouver, British Columbia  
Canada V6J 4S5

Some of the required documentation must be sent to the College directly from third parties (e.g. transcripts from universities, reference forms from supervisors). The College must receive all required documents, including all required professional and academic records and references before an application will be reviewed. Applicants are solely responsible for ensuring all application documents are delivered to the College.

**Delivery:** Applicants are encouraged to submit all application documents by registered mail or by courier. The College does not accept photocopies and faxed application material. The College accepts no responsibility for delays in its receipt of application materials.

**Deadline for completion:** Subject to any extensions granted by the College, applicants have *24 months* from the date your application and application fee are received to complete all necessary steps for registration, after which the application will automatically expire.

**The status of your application:** Applicants will be notified if application documents are insufficient or if further information is required.

## A. Contact Information

### 1. Names

a. Under section 21 of the *Health Professions Act*, the College must maintain a register containing the name of every registrant (the "Register"). Registrants must provide their *full legal names* and also any *professional, business or trade names*, past or present, and spelled or punctuated as actually used. **N.B.** If this information changes, you must inform the College in writing within 30 days of the change.

b. Full Legal Name of Applicant: \_\_\_\_\_

c. Former legal names used, if any: \_\_\_\_\_

d. Professional Name(s): \_\_\_\_\_

e. Choose one of the above names as the single name you will use for the application process, the College Register at the point of registration, and all College correspondence:

\_\_\_\_\_

2. Date of Birth (year / month / day): \_\_\_\_\_

3. Gender (male / female): \_\_\_\_\_

4. Place of Birth (city / province or state / country): \_\_\_\_\_

## B. Training and Competence Requirements

### Education - *Institution*

1. Provide the information requested below beginning with your most recent education. For Department, please provide the exact name of the department from which degree was received or in which work was done.

Applicants trained outside Canada and the United States must provide documentation showing their degrees have been reviewed by an international credentialing agency acceptable to the Registration Committee, and must provide documentation attesting to the foreign training being equivalent to a Canadian degree.

a. Name of College or University :  Graduate/Undergraduate (circle one)	Department:	Dates of attendance (from/to):
	Degree awarded:	Date awarded:
	Major subject:	Minor subject:
b. Name of College or University :  Graduate/Undergraduate (circle one)	Department:	Dates of attendance (from/to):
	Degree awarded:	Date awarded:
	Major subject:	Minor subject:
c. Name of College or University :  Graduate/Undergraduate (circle one)	Department:	Dates of attendance (from/to):
	Degree awarded:	Date awarded:
	Major subject:	Minor subject:
d. Name of College or University :  Graduate/Undergraduate (circle one)	Department:	Dates of attendance (from/to):
	Degree awarded:	Date awarded:
	Major subject:	Minor subject:
e. Name of College or University :  Graduate/Undergraduate (circle one)	Department:	Dates of attendance (from/to):
	Degree awarded:	Date awarded:
	Major subject:	Minor subject:

2. Title of Master's Thesis: \_\_\_\_\_  
Reference (if published): \_\_\_\_\_  
Name of Supervisor: \_\_\_\_\_

## C. Program of Study

The Registration Committee evaluates programs of study using the criteria outlined in Schedule H of the College bylaws.

*Applicants must submit a description of how their program meets each of the criteria outlined in Schedule H, Section II.A to E (School Psychologist Registration criteria) and attach this description to this application form.*

## D. Coursework

### 1. Category 1: Cognitive Assessment (Level C tests)

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

**2. Category 2: Professional Ethics (for Psychology or School Psychology)**

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

**3. Category 3: Academic Assessment and Intervention**

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

**4. Category 4: Typical and Atypical Child Development**

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

**5. Category 5: Psychometric Principles**

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	



**6. Category 6: Consultation**

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

## 7. Category 7: Social Emotional, Behavioural Assessment and Intervention

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

**8. Category 8: Psychopathology and Diagnosis of Intellectual Disability and Learning Disorders**

Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	
Course Title:	
Institution:	Brief Description of Course Contents :
Year Taken:	
Course No.:	
No. of Credits:	
Hours / week:	

## E. Official Transcripts

- Applicants MUST arrange for a complete OFFICIAL TRANSCRIPT of all courses and grades for graduate and undergraduate degrees to be sent from each educational institution concerned **directly** to the College.
- Applicants whose transcripts are not in English must submit translated and notarized copies of their transcripts, in addition to the original transcripts.

1. Please list below the institutions with which you have made arrangements for the College to receive transcripts:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

## F. Supervised Training

### 1. Practica

Provide details of all your supervised training experience such as practica, externships, clerkships and/or other supervised experience required as part of your professional training. Please start with the most recent and continue backwards.

a. Title/Name of position held:		
Start Date: (year/month)		End Date: (year/month)
Total Number of Hours of Practicum:		
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision (hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____		
_____		
_____		
_____		
Course Credit:		Course No.:
Year Taken:		Academic Institution:

b. Title/Name of position held:		
Start Date: (year/month)		End Date: (year/month)
Total Number of Hours of Practicum:		
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____ _____ _____		
Course Credit:		Course No.:
Year Taken:		Academic Institution:

c. Title/Name of position held:		
Start Date: (year/month)		End Date: (year/month)
Total Number of Hours of Practicum:		
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____ _____ _____		
Course Credit:		Course No.:
Year Taken:		Academic Institution:

d. Title/Name of position held:		
Start Date: (year/month)		End Date: (year/month)
Total Number of Hours of Practicum:		
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____ _____ _____		
Course Credit:		Course No.:
Year Taken:		Academic Institution:

e. Title/Name of position held:		
Start Date: (year/month)		End Date: (year/month)
Total Number of Hours of Practicum:		
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____ _____ _____		
Course Credit:		Course No.:
Year Taken:		Academic Institution:

## F. Supervised Training

### 2. Internship

Provide details of the internship completed as part of your school psychology training program.

*Applicants must submit a description of how their internship meets each of the criteria outlined in Schedule H, Section II.F (School Psychology Internship Criteria) and attach this description to this application form.*

Start Date: (year/month)	End Date: (year/month)
Name of organization or institution:	
Mailing address:	Services offered by organization or institution:
Name of Internship Director:	
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____ _____ _____ _____ _____ _____	
Course Credit:	Course No.:
Year Taken:	Academic Institution:

## G. Assessment of Competencies, Knowledge, and Area of Practice

### ***Declaration of Area of Practice***

Declaration of area of practice is expected to be based on completion of training and supervision in that area, as supported by documentation (transcripts, letter from director of training).

School Psychologist applicants must provide their declaration of competence in the area of school psychology, and are restricted to practising in that area in accordance with section 46(8) of the College bylaws.

1. Identify below by which method your declaration of area of practice is supported:

- Program completed is clearly identified on the transcript of the highest degree (e.g., School Psychology).
- A letter has been requested from my training director to be sent directly to the College attesting that a specific program was completed (e.g., School Psychology).

**If neither of these apply, applicants must complete Section 2 which follows.**









THIS FORM IS FORWARDED TO REFEREES. PLEASE WRITE YOUR NAME LEGIBLY BELOW.

Name of Applicant: \_\_\_\_\_

3. Please indicate your activities and services in the area of practice for which you have provided a declaration by placing a check (✓) next to the relevant sections in the table below.

**N.B.** A copy of this table will also be forwarded to the referees that you indicate will be providing a reference on your behalf.

<b>Activities and Services</b>	
<b>Area of Practice</b>	<b>School Psychology</b>
<b>Assessment</b>	
<b>Intervention</b>	
<b>Consulting</b>	
<b>Teaching</b>	
<b>Supervision</b>	
<b>Research</b>	
<b>Program Evaluation</b>	

Ages of Clients: \_\_\_\_\_

Types of Clients (e.g., individuals, families, organizations):

\_\_\_\_\_

Explanatory Notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## H. Good Character and Fitness Requirements

Please answer each of the questions below. A separate sheet explaining any “yes” answer is required along with any supporting documents.

A separate sheet explaining any “yes” answer is required	Yes	No
1. Have supervisors or others ever raised questions with you about your suitability or competence to practice psychology, or your competence to carry out professional tasks or duties?		
2. Have you ever been censured, reprimanded, dismissed, suspended, terminated, or asked to resign, or has any disciplinary action been taken against you during your education, training or employment as a mental health professional?		
3. Have you ever been rejected or barred from applying for, or denied registration, certification or licensing as a psychology practitioner or any other profession in any jurisdiction?		
4. Are you now, or have you ever been, disciplined, convicted, censured, reprimanded, sanctioned, suspended, disqualified, prohibited from practicing or penalized in any manner by any professional regulatory body at any level of membership or has your license to practice any profession been revoked or made subject to terms or conditions?		
5. Have you ever voluntarily surrendered or relinquished a license to practice psychology or any other profession, or surrendered or allowed a license to practice psychology or any other profession lapse due to action pending or threatened?		
6. Are you the subject of a current proceeding or outstanding/unresolved complaint against you for professional misconduct, incompetence, or incapacity in relation to the profession of psychology or other profession?		
7. Have you ever been found to have committed professional malpractice by a court or tribunal?		
8. Are you currently named as a defendant in any civil proceeding in which professional malpractice or negligence is alleged?		
9. Do you have any pre-existing or current conditions of a disability, physical ailment, emotional disturbance or an addiction of any kind that might impair your ability to practice psychology, complete the application process (including written, computerized, oral examinations), interact with the College, clients, or the court?		
10. Have you ever been convicted, plead guilty, or plead <i>nolo contendere</i> to any criminal offence? If yes, provide details on the following and include a statement on whether or not you consider this conviction relevant to the profession of psychology: Nature, date, place of conviction.		
11. Has there ever been a finding of contempt of court made against you, or have you ever been found to have contravened or failed to comply with any order of any Court?		
12. Are there any or have there ever been any restrictions or limitations on your license to practice psychology or any other profession?		
13. Is there any event, circumstance, condition or matter touching on your conduct, character, or reputation which you believe might raise a significant material concern for you, a reasonable registrant, a reasonable member of the public, or your intended class of clients, respecting your registration as a psychology practitioner?		

## I. Certificate of Standing / Professional Record

1. Provide the following information regarding previous and current applications, as well as previous and current registration, certification, or licensure, as a school psychologist, psychologist or a member of any health profession in any jurisdiction

a. Name of professional regulatory body:	
Date of issuance of original professional license or certificate (year/month/day):	Professional license or certificate number:
Has registration been continuous? Yes/No. If no, please provide details.	
Title of registration	
Mailing address: _____ _____	Telephone: _____
	Facsimile: _____

b. Name of professional regulatory body:	
Date of issuance of original professional license or certificate (year/month/day):	Professional license or certificate number:
Has registration been continuous? Yes/No. If no, please provide details.	
Title of registration	
Mailing address: _____ _____	Telephone: _____
	Facsimile: _____

If you have additional licenses, certificates or registrations, which cannot be accommodated on this Application Form, please attach additional sheets providing this information.

Applicants must arrange for verification of licensure to be sent by the regulatory body(ies) **directly** to the College. Copies of the required verification forms are available on the College website.

2. Please provide below the details of a complete record of your professional employment experience. Please start with the most recent and continue backwards.

<b>a. Title/Name of position held:</b>		
Start Date: (year/month)		End Date: (year/month)
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____		
_____		
_____		
_____		

<b>b. Title/Name of position held:</b>		
Start Date: (year/month)		End Date: (year/month)
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____		
_____		
_____		
_____		

<b>c. Title/Name of position held:</b>		
Start Date: (year/month)		End Date: (year/month)
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____		
_____		
_____		
_____		

<b>d. Title/Name of position held:</b>		
Start Date: (year/month)		End Date: (year/month)
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____		
_____		
_____		
_____		



<b>e. Title/Name of position held:</b>		
Start Date: (year/month)		End Date: (year/month)
Full-time or Part-time:		If Part-time, hours per week:
Direct client contact (hours per week):	Individual supervision ( hours per week):	Group supervision (hours per week):
Name of organization or institution:		
Mailing address:		Services offered by organization or institution:
Supervisor's name and profession:		
Your duties and responsibilities (include a description of clients seen and services provided, e.g., presenting problem, type of service, area of practice, age of clients): _____		
_____		
_____		
_____		

Please attach additional sheets if necessary.

## J. Criminal Record and Police Checks

### 1. Criminal Records Review Program

All applicants must undergo a criminal record review through the provincial government's [Criminal Records Review Program \(CRRP\)](#). For many applicants, this can be completed online. Please review the "[Applicant Guide](#)" and "[FAQ](#)" document. You will need the College specific access code (GDM74JX5TR) to complete the process.

Applicants without a BC Services Card who haven't lived in B.C. for at least six months or who live outside the province should follow this [link](#) to request a consent to a criminal record request form from the College. You will need to complete the form and return it to the College along with copies of two [acceptable forms of ID](#). The Criminal Records Review Program does not allow organizations to post this form publicly.

N.B. The College does not accept shared results of a criminal record check previously completed with the Criminal Records Review Program for another organization.

### 2. National Police Check(s)

Applicants must submit original documentation providing the results of a national police check or the equivalent for every jurisdiction in which the applicant resided during the five-year period immediately before the date of application, if it is not reasonably practicable to obtain such documentation for the applicable jurisdiction, a letter of explanation is required and will go before the Registration Committee.

For Canadian jurisdictions, the check must be completed by the police or RCMP. For US jurisdictions, the check must be completed by the FBI. For all other jurisdictions, a national check must be completed by the police or an equivalent authority. Each check must be the most comprehensive check available in terms of coverage of records checked.

Applicants must arrange for completed police check(s) to be sent directly to the College.

## K. References

1. Please list below the names, positions, and addresses of the three psychologists / school psychologists to whom we will forward:
  - a. the reference form,
  - b. a copy of your completed activities and services grid,
  - c. the completed "Supervision Information for Referees" form below,
  - d. a copy of the statutory declaration you signed as part of this application form, and
  - e. any other supporting documents the College deems useful for the completion of the reference.

(1). Name:	
Mailing address:	Telephone:
	Facsimile:
	E-mail:
(2). Name:	
Mailing address:	Telephone:
	Facsimile:
	E-mail:
(3). Name:	
Mailing address:	Telephone:
	Facsimile:
	E-mail:

2. Complete the forms on the following three pages with respect to the supervised experience you received with each above-named referee. **N.B.** Each completed form will be forwarded by the College to the referee along with a reference form, and the materials outlined above.

# (1) SUPERVISION INFORMATION FOR REFEREES

Name of Applicant: \_\_\_\_\_

Name of Referee (Internship Director y/n): \_\_\_\_\_

Title/Name of position held by Applicant at time of supervision:		
Start Date: (year/month)		End Date: (year/month)
Direct client contact supervised by this referee (hours per week):	Individual supervision with this referee (hours per week):	Group supervision with this referee (hours per week):
Name of organization or institution:		
Please describe the professional training experiences provided under supervision with this referee.		
(i) Age range of clients: _____ _____ _____		
(ii) Presenting problems of clients: _____ _____ _____		
(iii) Types of assessments provided: _____ _____ _____		
(iv) Assessment instruments used: _____ _____ _____		
(v) Intervention / Consultation: _____ _____ _____		

## (2) SUPERVISION INFORMATION FOR REFEREES

Name of Applicant: \_\_\_\_\_

Name of Referee (Internship Director y/n): \_\_\_\_\_

Title/Name of position held by Applicant at time of supervision:		
Start Date: (year/month)		End Date: (year/month)
Direct client contact supervised by this referee (hours per week):	Individual supervision with this referee (hours per week):	Group supervision with this referee (hours per week):
Name of organization or institution:		
Please describe the professional training experiences provided under supervision with this referee.		
(i) Age range of clients: _____		
_____		
_____		
(ii) Presenting problems of clients: _____		
_____		
_____		
(iii) Types of assessments provided: _____		
_____		
_____		
(iv) Assessment instruments used: _____		
_____		
_____		
(v) Intervention / Consultation: _____		
_____		
_____		

### (3) SUPERVISION INFORMATION FOR REFEREES

Name of Applicant: \_\_\_\_\_

Name of Referee (Internship Director y/n): \_\_\_\_\_

Title/Name of position held by Applicant at time of supervision:		
Start Date: (year/month)		End Date: (year/month)
Direct client contact supervised by this referee (hours per week):	Individual supervision with this referee (hours per week):	Group supervision with this referee (hours per week):
Name of organization or institution:		
Please describe the professional training experiences provided under supervision with this referee.		
(i) Age range of clients: _____		
_____		
_____		
(ii) Presenting problems of clients: _____		
_____		
_____		
(iii) Types of assessments provided: _____		
_____		
_____		
(iv) Assessment instruments used: _____		
_____		
_____		
(v) Intervention / Consultation: _____		
_____		
_____		

## L. Additional items

1. **Professional Liability Insurance.** Prior to registration, all applicants must provide evidence satisfactory to the Registration Committee of professional liability insurance coverage in an amount not less than \$1,000,000 per occurrence.
2. **Supervision.** For applicants currently providing, or planning to provide, psychological services in BC during the application period:

*I have, or will arrange to have, a Registered Psychologist or School Psychologist supervisor for any psychological services I provide in British Columbia while an applicant for registration. I agree to submit a supervision plan, cosigned by the Registered Psychologist or School Psychologist supervisor, including the name of the supervisor who has agreed to provide supervision and a description of proposed arrangements. I understand that the supervisor will complete a short form at the time I complete my last exam to confirm that the supervision took place according to the plan submitted. \_\_\_\_\_ (initial here)*

## M. Enclosure Checklist

Prior to review of your application, the following documentation must be received by the College. Please confirm below that these documents have been submitted with your application or that you have arranged for them to be sent directly to the College.

<b>LIST OF REQUIRED DOCUMENTATION</b>		
<b>Please review the documents below and confirm that all the required documents that pertain to your application for registration have been enclosed or requested.</b>		
1.	Curriculum vitae is enclosed.	
2.	Completed application form is enclosed.	
3.	Application Fee is enclosed.	
4.	A complete response providing information about program of study is enclosed.	
5.	A complete response providing information about internship is enclosed.	
6.	Translated and notarized copies of transcripts which are not in English are enclosed.	
7.	<b>For Applicants trained outside Canada and the United States:</b> Documentation showing their degrees have been reviewed by an international credentialing agency as equivalent to a Canadian degree.	
8.	Transcripts for all undergraduate and graduate training have been requested to be mailed directly to the College.	
9.	Requests have been submitted to all current or previous professional regulatory bodies to provide verification of registration to be mailed directly to the College.	
10.	Completed authorization form for Criminal Record Review OR online completion through Criminal Records Review Program. <b>N.B.</b> In British Columbia, all applicants are required by the <i>Criminal Records Review Act</i> to provide this authorization.	
11.	All required Police check(s).	
12.	Supervision plan.	



## N. Statutory Declaration

I (full legal name) \_\_\_\_\_  
of (full address) \_\_\_\_\_

DO SOLEMNLY DECLARE that the statements and all of the information provided by me in this application for registration are complete, accurate and true.

I ACKNOWLEDGE that the College of Psychologists of British Columbia (the "College") may request additional information concerning my application for registration, and I HEREBY AUTHORIZE the College to obtain any further information relevant to my application for registration from ANY PERSON, INCLUDING BUT NOT LIMITED TO persons or institutions referred to in my application documents.

I RELEASE all individuals and institutions, including those who provide a reference for me, from any liability which might arise from them providing information to the College.

I ACKNOWLEDGE that third persons may inquire of the College concerning my application status, and I HEREBY AUTHORIZE the College to provide information concerning the status of my application, including but not limited to completed and pending steps.

I ACKNOWLEDGE that it is an offence to apply to be registered as member of the College if I know that I am not qualified to be a registrant.

I UNDERTAKE to advise the College, while I am an applicant for registration or a registrant, of any changes to my legal or professional name(s), and any changes to my address information, within 30 days of any such change(s).

I MAKE THIS SOLEMN DECLARATION conscientiously believing it to be true and knowing that it has the same force and effect as if made under oath.

**Declared** before me at \_\_\_\_\_ )  
in the Province/State of \_\_\_\_\_ )  
this \_\_\_\_ day of \_\_\_\_\_ )  
\_\_\_\_\_ in the year \_\_\_\_\_ )

Signed: \_\_\_\_\_ )  
A Commissioner for Oaths, Notary Public or )  
Justice of the Peace in \_\_\_\_\_ )  
Printed name of Commissioner: \_\_\_\_\_ )  
Physical address: \_\_\_\_\_ )  
\_\_\_\_\_ )  
\_\_\_\_\_ )  
Phone: \_\_\_\_\_ )

\_\_\_\_\_  
Declarant's Signature