



Application for Licensure

1. Personal information

Full legal name First _____ Middle _____ Last _____

Name you go by _____

Other names _____

Birthdate Day _____ Month _____ Year _____

Pronouns he/him ☐ he/they ☐ she/her ☐ she/they ☐ they/them ☐ ze/zir ☐
Use my name/no pronouns ☐ Prefer not to say ☐ Other ☐: _____

Sex at birth Female ☐ Intersex ☐ Male ☐ Prefer not to say ☐

2. Contact information

Phone Home _____ Mobile _____

Email address _____

Mailing address _____ City _____

Province _____ Postal code _____ Country _____

3. Indigenous self-identification

Do you self-identify as an **Indigenous** person? Yes ☐ No ☐ Prefer not to answer ☐

If *Yes*:

With which group(s) do you identify? First Nations ☐ Métis ☐ Inuit ☐

Do you **consent to being contacted by CHCPBC** regarding opportunities to provide your perspectives on regulatory issues as an Indigenous healthcare provider? Yes ☐ No ☐

4. Application type

Audiology Full ☐ Conditional ☐

Hearing Instrument Dispensing Full ☐ Conditional ☐

Speech-Language Pathology Full ☐ Conditional ☐



5. Education

Educational institution _____

Qualifying credential _____

Year of graduation _____

6. Registration in other jurisdictions

Are you currently or were you at any time previously **registered as a health professional or other regulated professional in another Canadian province or territory?**

Yes, currently ☐ Yes, previously ☐ No ☐

If *Yes*, please specify the profession, province(s) or territory/territories, and registration dates (including current and past).

Are you currently or were you at any time previously **registered as a health professional or other regulated professional in another country?**

Yes, currently ☐ Yes, previously ☐ No ☐

If *Yes*, please specify the profession, country/countries, and registration dates (including current and past).

7. Professional liability insurance

Provider name _____

Effective date Day _____ Month _____ Year _____

Expiry date Day _____ Month _____ Year _____

8. Employment information

You will have the opportunity to make changes or enter additional employers after your registration has been approved. Leave this section blank if you are not currently employed.

Primary employment

**Employer/
organization** _____

Work address _____ City _____

Province _____ Postal code _____ Country _____

Work phone _____

Work email _____

Supervisor Name _____ CHCPBC Licence Number _____



Secondary employment

**Employer/
organization**

Work address

_____ City _____

Province _____ Postal code _____ Country _____

Work phone

Work email

Supervisor

Name _____ CHCPBC Licence Number _____

9. English language proficiency

If you completed an **acceptable academic program**, as defined in the College's [Bylaws](#), that was **delivered in English** (including all academic learning and clinical practice), you will be exempt from completing English language proficiency testing.

or

If you are not exempt, you must **complete a TOEFL (iBT) or IELTS (AC or GT) English test** and meet the [required minimum test scores](#).

Arrange to **have your English language proficiency scores sent directly to CHCPBC**. Successful completion of one of the approved tests must be no more than two years before the date of application to the College.

A. I have completed an acceptable academic program that was delivered in English. ☐

B. I will arrange to have my English language proficiency testing scores sent to CHCPBC. ☐

10. Information collection

By completing this application, I authorize CHCPBC to investigate and/or verify any information supplied in this application. CHCPBC may request and/or collect additional information and records from third parties that it considers relevant to this application. I consent to both the collection and use of such information and records by CHCPBC for the purposes of assessing whether I meet the requirement for registration. I further consent to CHCPBC's disclosure of my personal information to the extent necessary to verify the information that I have provided or for the purposes of gathering additional information to assess my application. I also consent to CHCPBC's disclosure of my personal information for national and provincial reporting for the purposes of health human resource planning and for the Ministry of Health Provider Registry.

I acknowledge and accept the above declaration. ☐

Applicant signature

Date