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 ☐

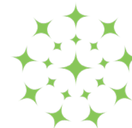
If *Yes:*

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

Dietitian Full ☐ Provisional ☐



5. Canadian Dietetic Registration Examination

Have you successfully completed the Canadian Dietetic Registration Exam (CDRE)? Yes ☐ No ☐ Upcoming (provide date) ☐ : ____________________

6. Education

Educational institution ____________________

Qualifying credential ____________________

Year of graduation __________

7. 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). ____________________

8. Professional liability insurance

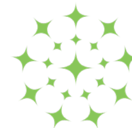
A licensee must obtain and at all times maintain professional liability insurance in an amount of at least $2,000,000 per claim or occurrence. Insurance coverage must be continuous, i.e., without interruption for the duration of the licensure.

Provider name ____________________

Effective date Day ______ Month __________ Year ______

Expiry date Day ______ Month __________ Year ______

The College of Health and Care Professionals of British Columbia collects, uses, and discloses personal information in accordance with the *Freedom of Information and Protection of Privacy Act* (FOIPPA), the *Health Professions and Occupations Act* (HPOA), and other applicable laws (including the CHCPBC Bylaws).



9. 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.

If you are applying for Provisional licensure, you must also complete the Supervision Agreement.

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 __________

10. 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.

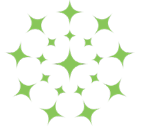
A. I have completed an acceptable academic program that was delivered in English. ☐

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.

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



11. 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**