College of
HEALTH AND CARE
PROFESSIONALS OF BC

IDENTITY PROTECTION ORDER

Application

pursuant to section **235(1)** of the *Health Professions and Occupations Act* ("HPOA")

Your contact information

Title (e.g., Mr., Ms., Mx., Dr.): _____ **Pronouns:** _____

First name: _____ **Last name:** _____

Preferred name: _____

Address: _____ **City:** _____

Province: _____ **Postal code:** _____ **Country:** _____

Phone: _____ **Email:** _____

Matter in which you seek an identity protection order

Licensee name: _____ **Case ID** (if known): _____

Subject of the application

Whose identity are you applying to protect?

☐ My own ☐ Another's (the "Other Person")

Other Person's name: _____

Your relationship to the Other Person: _____

Eligibility

To qualify for an identity protection order, you (or the Other Person) must meet one of the following criteria. Select all that apply:

☐ I made a regulatory complaint.

☐ I made a regulatory complaint on behalf of the Other Person.

☐ I made a regulatory report.

☐ I (or the Other Person) assisted or gave information or records to an investigator or some other person acting under the HPOA.

☐ I (or the Other Person) received health services from a licensee who was not—or might not have been—fit to practise.

☐ I (or the Other Person) experienced licensee conduct that may have been an act of misconduct.

Reasons

How might you (or the Other Person) be negatively impacted if your (or the Other Person's) identity and/or involvement in this matter were disclosed to the licensee, witnesses, or the public?

Extent of protection

What level of protection are you seeking?

- ☐ Full anonymity - The College would not disclose your identity to anyone, not even the licensee.
- ☐ Partial anonymity - The College might disclose your identity to the licensee or to witnesses as part of an investigation, but not to the general public.
- ☐ I am not sure (A CHCPBC staff member will contact you to discuss further.)

Declaration

In application for an Identity Protection Order under the HPOA, I certify that the information I have provided herein is true and complete to the best of my knowledge.

I understand that a decision maker will consider various factors, pursuant to section **237(1)** of the HPOA, and that I may be contacted for further information.

Signature: _____ Date: _____