



SUPPORT PROGRAMS

Application

pursuant to Part 5, Division 5 of the [Health Professions and Occupations Act](#) (“HPOA”)

The CHCPBC Support Programs are for people who have experienced sexual abuse, sexual misconduct, or discrimination by a CHCPBC licensee.

Steps:

1. Before completing this form, ensure that a Complaint Form has been submitted.
2. Complete all relevant sections of this form.
3. If you are filling this form out for someone else, you will also need to fill out the Support Programs Authorization for Representation.
4. Make sure everyone has signed all the spots where we need a signature.
5. When you are ready, send the completed application to us at supportprograms@chcpbc.org.

If you need assistance filling out this form, we can help you. Call us Monday to Friday, 8:30 a.m. to 4:30 p.m. at 604-742-6715 or toll-free at 1-877-742-6715, or email us at supportprograms@chcpbc.org.

I am:

- The **recipient** (the person who will receive services through the Support Programs)
- The **representative** (a person applying on behalf of the recipient)

Recipient information

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

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

Preferred name: _____

Address: _____ **City:** _____

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

Phone: _____ **Email:** _____



Representative information

Leave this section blank if you are the recipient.

Title (e.g., Mr., Ms., Mx., Dr.): _____ **Pronouns:** _____
First name: _____ **Last name:** _____
Preferred name: _____
Address: _____ **City:** _____
Province: _____ **Postal code:** _____ **Country:** _____
Phone: _____ **Email:** _____
Relationship to recipient: _____

Have you completed the [Support Programs Authorization for Representation](#) form?
Note: This is separate from the Authorization for Representation form for the complaint.

We need the recipient's permission to share information with a representative. When we review the application, we collect the recipient's personal information.

The Support Programs Authorization for Representation form helps confirm the representative's authority to represent the recipient and receive such information on their behalf. We cannot review the application without the recipient's permission. If you have questions on what to provide as a representative, please contact the Support Officer at 604-742-6715 or toll-free at 1-877-742-6715, or email supportprograms@chcpbc.org.

This application is for:

Information services Support services Support worker

Learn more about these areas of the Support Programs on the CHCPBC [website](#).

Declaration

I confirm the following:

- I understand that with consent, CHCPBC will share some or all of the information and documents it receives from the applicant, recipient, and other parties with the designated support worker.
- I understand that the information in this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act* and the *Health Professions and Occupations Act*. The information provided will be used to process my application.

Recipient's signature _____ Date _____

Representative's signature _____ Date _____

Thank you for taking the time to complete this form. We will review your application and contact you.