



## CHCPBC Equivalency Assessment Information Form

### 1. Personal Information

**Full Legal Name**    **First** \_\_\_\_\_ **Middle** \_\_\_\_\_ **Last** \_\_\_\_\_

**Name you go by** \_\_\_\_\_

**Other Names** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Pronouns**     he/him     he/they     she/her     she/they     they/them  
 Use my name/no pronouns     Prefer not to say     Other: \_\_\_\_\_

**Sex at Birth**     Female     Male     Intersex     Prefer not to say

### 2. Contact information

**Phone** \_\_\_\_\_    **Home** \_\_\_\_\_    **Mobile** \_\_\_\_\_

**Email address** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

### 3. Profession Applying For:

Audiology     Hearing Instrument Dispensing     Speech-Language Pathology

### 4. Education

#### Education 1

Education Institution \_\_\_\_\_

Qualifying Credential \_\_\_\_\_

Country \_\_\_\_\_ Year of graduation \_\_\_\_\_

#### Education 2 (if applicable)

Education Institution \_\_\_\_\_

Qualifying Credential \_\_\_\_\_

Country \_\_\_\_\_ Year of graduation \_\_\_\_\_

#### Relevant documents

Please refer to the [Required Documents](#) for detailed submission requirements.

- Official transcripts
- Academic Coursework Requirements Form
- Educational credential evaluation
- Course outlines / syllabi
- Summary of Clinical Practicum Hours Form

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).



## 5. Professional Practice Experience

Regulated Practice? Yes  No

*Relevant documents (if applicable)*

Current CV / Resume

Employer verification letter(s) (*must be sent directly from the employer to CHCPBC*)

Additional documents may be requested following further review.

## 6. Entry to Examination

Have you successfully completed an CHCPBC approved entry-to-practice examination?

Yes  No

If yes, please specify:

Praxis Examination (5331 or 5343)

CETP Examination

Other: \_\_\_\_\_

## 7. Licensure in other jurisdictions

Are you currently or were you at any time previously registered as a health professional in another Jurisdiction outside of British Columbia?

Yes, currently  Yes, previously  No

If yes, please specify the profession, jurisdiction, and registration dates

## 8. Additional Information

## 9. 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

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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
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