College of
HEALTH AND CARE
PROFESSIONALS OF BC

Support Programs Application Form

An eligible person – or their authorized representative – may use this fillable form to apply for support services and/or the assistance of a support worker. For details on these support programs, please visit the College **website**.

All fields are required unless otherwise noted.

If you have questions about completing this form or need assistance, please contact us:

- Phone: 604-742-6715 or 1-877-742-6715 (toll-free)
- Email: **complaints@chcpbc.org**

Licensee

Who is the complaint about?

Last Name: _____

First Name: _____

Profession: _____

Case ID (if known): _____

Applicant

Who is making the application?

Last Name: _____

First Name: _____

Pronouns (optional): _____

Mailing Address: _____

Email: _____

Phone: _____

Communication Needs/Preferences

☐ I require an interpreter. Language: _____

Preferred contact method: ☐ Email ☐ Phone ☐ Mail

Can we leave a voicemail: ◯ Yes ◯ No

Program

What type of support is requested? Select one or both.

☐ **Support Services:** The College can facilitate access to counselling and trauma-informed cultural supports to support people who have experienced sexual misconduct, sexual abuse, or discrimination by a CHCPBC licensee.

☐ **Support Worker:** The College can assign an independent, experienced, and qualified support worker to support people who have experienced sexual abuse, sexual misconduct, and/or discrimination by a CHCPBC licensee.

The support worker can help explain your rights and role in the complaints process and accompany you to interviews or hearings regarding the complaint.

Recipient

If approved, who will receive the support? Note: This must be the person who experienced the sexual misconduct, sexual abuse, or discrimination.

◯ I am making this application on my own behalf.

◯ I am making this application on behalf of the person named below ("Recipient").

Last Name: _____

First Name: _____

Pronouns: (optional) _____

Mailing Address: _____

Email: _____

Phone: _____

☐ I have a completed **Authorized Representative – Support Programs form** ready to submit with this application.

Privacy

☐ I understand the information on this form is collected under the authority of the *Freedom of Information and Protection of Privacy Act* (FIPPA) and the *Health Professions and Occupations Act* (HPOA).

☐ I understand the information provided will be used and disclosed, as permitted by law (including FIPPA and HPOA), to process this application.

Submit

You may submit the completed form by:

- **Email:** complaints@chcpbc.org
- **Fax:** 604-608-9863
- **Mail:** 900-200 Granville Street, Vancouver, BC V6C 1S4