College of
HEALTH AND CARE
PROFESSIONALS OF BC

CERTIFICATION PROGRAMS

APPLICATION TO PERFORM CERTIFIED PRACTICE

Applicant information

Applicant name _____ Licence # (7 digits) _____

Certification program (Select one) _____

Certification program pre-requisites

Pre-requisites are listed within each **certification program** and must be met before starting a program. The following information and supporting documentation must be provided.

Full licensure

Applies to all certification programs

Full licensure effective date _____

Pre-requisite course

Applies to any certification program listing a pre-requisite course

☐ I have completed the required pre-requisite course. *or* ☐ N/A

Attach proof of successful course completion issued by the course provider, including:

- Course name
- Number of course hours
- Organization name and contact information
- Proof and date of successful completion

Attach course content description.

Work experience option

Applies to Videofluoroscopy of Paediatric Velopharyngeal Disorders only

For this certification program, if you have **not completed the required graduate-level course**, you may use **at least one year of current, related clinical work experience** to meet this requirement.

☐ I am using relevant clinical work experience to meet this requirement. *or* ☐ N/A

The work experience must have been completed:

- as a licensee in BC, *or*
- as a health professional authorized to practise the equivalent restricted activity in another jurisdiction in Canada

Attach an employment verification letter from each employer, including:

- workplace name and contact information
- start date of work as a licensed health professional (Provisional and Full licensure experience may be counted)
- a description of the relevant clinical work experience, including activities performed

Certification program requirements
Applies to all certification programs

Certification program start date _____ End date _____

Attach completed **Supervision Declaration form**.

Licensee declaration

- ☐ I acknowledge that my profession, including the certified practice I am applying for, is regulated in accordance with the *Health Professions and Occupations Act* (HPOA), Regulated Health Practitioners Regulation, Health and Care Professionals Regulation, CHCPBC Bylaws, and Ethics and Practice Standards.
- ☐ I confirm that I have sufficient knowledge, skills, judgement, and confidence to perform this certified practice competently and safely.
- ☐ I understand that I need to fulfill any Professional & Quality Practice Program requirements in order to continue to perform this certified practice.
- ☐ I understand that a certified practice must be renewed annually.
- ☐ I certify and declare that the information provided in this application is true.

If the Registrar has reasonable grounds to believe a licensee has included a false or inaccurate statement, the Registrar may make a regulatory complaint about the licensee pursuant to section 119 of the HPOA.

Signature _____ Date _____

Submit this form and all supporting documentation to **certification@chcpbc.org**, including the name of the certification program in the subject line. Your application will be reviewed, and, if eligible, you will be prompted to pay the $250 application fee. *The application fee is non-refundable.*

After you make the payment, you will receive confirmation of your certification by email and should verify that the correct certification is published on the **Public Registry** under your name.

If you do not receive confirmation and the certified practice is not displayed on the Public Registry, you are not authorized to perform this activity.

Supporting documentation attached:

- ☐ Proof of successful course completion
- ☐ Course content description
- ☐ Employment verification letter(s)
- ☐ Supervision Declaration form