College of
HEALTH AND CARE
PROFESSIONALS OF BC

CERTIFICATION PROGRAMS

APPLICATION TO PERFORM INTRAPELVIC HEALTH

Applicant information

Applicant name _____ Licence # (7 digits) _____

Are you currently a Full licensee of CHCPBC? ☐ Yes ☐ No

Certification program start date _____ End date _____

Certification program requirements

Review the **certification program** and the **Competency Framework for Intrapelvic Health** carefully. You are responsible for ensuring that you meet all learning objectives and competencies listed for at least one of the competency profiles detailed in the framework.

With this application, attach proof of successful **course completion** (certificate or letter issued by the course provider). The following information is required:

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

Additionally, attach a **course content description**.

* A Full licensee in good standing must start and complete the required course work and evaluated practice within the three years immediately before they apply for the certified practice. If you started or completed your course more than three years ago, we will ask you for more information.

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 attained the **learning objectives and competencies** for the intrapelvic health practice(s) I intend to perform.

☐ 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 your course completion documentation (certificate/letter and course content description) to **certification@chcpbc.org**, using the subject line “Intrapelvic Health Application.” 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.