College of
HEALTH AND CARE
PROFESSIONALS OF BC

Certificate of Standing

SECTION 1 – CONSENT FOR RELEASE OF INFORMATION
This Section is to be completed by the Applicant. A copy of this Consent for Release of Information is to be sent the regulatory authority (College, Board or Association) in every jurisdiction in which the Applicant has ever practised optometry or other health profession together with a copy of the attached Certificate of Standing.

I, Dr. _____
First Name Last Name
have applied to the College of Health and Care Professionals of BC for a Certificate of Registration in order to engage in the practice of optometry in British Columbia.

The College of Health and Care Professionals of BC, as part of its registration process, requires that a Certificate of Standing form be completed by every jurisdiction in which I was licensed and/or engaged in the practice of optometry, or any other health profession. As most jurisdictions require my consent to release the requested information, I am hereby signing my permission to and irrevocably authorize and direct the

_____
[name of regulatory authority]
to provide, at my expense, the information requested by the College of Health and Care Professionals of BC. I understand and accept that this means that you will be providing full disclosure of any and all information requested on the attached form or any additional information determined by the College of Health and Care Professionals of BC to be relevant to my application for registration.

I acknowledge that the College of Health and Care Professionals of BC has advised me that I have the right to obtain legal advice prior to executing this consent, and that I have either done so or have had sufficient opportunity to do so prior to executing this Consent for Release of Information. I am signing this document of my own free will, voluntarily and without coercion, having read it and having understood it.
IN WITNESS WHEREOF I have duly executed this Consent for Release of Information form this_____day of_____, 20_ .

_____
[printed name of Applicant]

_____
[signature of Applicant]

_____
[printed name of witness]

_____
[signature of witness]

SECTION 2 – CERTIFICATE OF STANDING
This Section is to be completed by the regulatory authority and returned by the regulatory authority directly to the College of Health and Care Professionals of British Columbia by e-mail:
registration@chcpbc.org

The _____
[name of regulatory authority]
records indicate the following information (where available) concerning:

Name: _____
[first name] [last name]

Registration Number: _____

Current primary professional address: _____

1. Registration Status

(i) The Applicant has been registered / licensed in_____from_____(M/D/Y) to_____(current or M/D/Y).

(ii) Is the Applicant currently practising in your province? ☐ YES ☐ NO

If YES, please indicate the period of time the Applicant has been practising in _____

from_____(M/D/Y) to_____(current or M/D/Y).

(iii) If the Applicant ceased to be a registered/licensed member, please specify the reasons below:
_____
_____
_____

(iv) The Applicant currently holds or previously held
a. a General Registration / Licence from_____(M/D/Y/) to _____ (current date or M/D/Y/).
b. a Temporary Registration / Licence from_____(M/D/Y/) to _____ (current date or M/D/Y/).
c. an Academic Registration / Licence from_____(M/D/Y/) to _____ (current date or M/D/Y/).

(v) Does the Applicant have the authority to prescribe drugs in your jurisdiction?

☐ YES ☐ NO

(vi) To the best of your knowledge, is or has the Applicant also been registered/licensed to practise of optometry or_____, or engaged in the practice of optometry or_____in any other jurisdiction(s)?

☐ YES ☐ NO

If YES, please provide details below:

Jurisdiction	Registere /Licensed From	To
	(M/D/Y)	(M/D/Y)
	(M/D/Y)	(M/D/Y)
	(M/D/Y)	(M/D/Y)

(vii) Is the Applicant in arrears of any fees or other monies owing to your organization?

☐ YES ☐ NO

If YES, please provide details below:

_____
_____
_____

(viii) Does the Applicant have or has the Applicant ever had any restrictions, terms, conditions or limitations on his or her Certificate/Licence?

☐ YES ☐ NO

If YES, please provide details below:

_____
_____
_____

(ix) Has the Applicant ever had his or her Certificate/Licence suspended, cancelled, revoked or struck off the Register/Roll?

☐ YES ☐ NO

If YES, please provide details below:

_____
_____
_____

2. Professional Conduct Record

i. Complaints

Has your organization ever received a formal complaint regarding the Applicant that has not been dismissed or found to be unsubstantiated?

☐ YES ☐ NO

If YES, please provide details of any investigations(s) that is/are in progress or have been completed by your organization and the disposition (please provide copies of any reason).

_____
_____
_____

ii. Discipline Proceedings

Has your organization ever initiated a discipline proceeding with respect to the Applicant?

☐ YES ☐ NO

If YES, please provide details of any hearing(s) that is/are in progress or have been completed by your organization with a decision / action being issued (including dismissing the allegations) or that involved the Applicant's resignation.

_____
_____
_____

iii. Fitness to Practise (including physical or mental condition or illness)

In the last two years, has your organization initiated a fitness to practise hearing or inquiry with respect to the Applicant?

☐ YES ☐ NO

If YES, please provide details of any hearing(s) that is/are in progress or have been completed by your organization with a decision / action being issued (including dismissing the allegations) or that involved the Applicant's resignation.

_____
_____
_____

iv. Quality Assurance Programs

Has the Applicant ever been the subject of a professional inspection other than regularly scheduled or randomly selected inspections?

☐ YES ☐ NO

If YES, please provide details of any inspection(s) that is/are in progress or have been completed by your organization with a decision / action being issued or that involved the Applicant entering into an Agreement or Undertaking with your organization.

_____

_____

_____

v. Continuing Education Requirements

Has the Applicant ever failed to be in compliance with your continuing education requirements?

☐ YES ☐ NO

If YES, please provide details of the nature of non-compliance and the action taken, if any.

_____

_____

_____

vi. Currency of Practice Requirements

Has the Applicant ever failed to be in compliance with your practice hours requirement?

☐ YES ☐ NO

If YES, please provide details of the nature of non-compliance and the action taken, if any.

_____

_____

_____

vii. Agreements and Undertakings

Has the Applicant ever entered into an Agreement or Undertaking with your organization?

☐ YES ☐ NO

If YES, please provide details of the nature of the Agreement or Undertaking and the current status.

_____
_____
_____

viii. Please provide details of any other relevant information that has been reported to you.

_____
_____
_____

Are other sheets/documents attached to this form?

☐ YES ☐ NO

Certification

_____
Signature **Title**

_____
Signed and sealed this date

This completed form should be e-mailed by the Regulatory Authority directly to:

College of Health and Care Professionals of BC
Licensure Team: registration@chcpbc.org