

College of Occupational Therapists of British Columbia

New Registrant Application Form



Personal Information

Surname		Given Name(s)	
Ms. <input type="checkbox"/>	Mr. <input type="checkbox"/>	Dr. <input type="checkbox"/>	Previous Name(s)
Address			
			Postal Code
Phone		Fax	
Email		Date of Birth DD / MM / YY	Female <input type="checkbox"/> Male <input type="checkbox"/>

Mutual Recognition Agreement

Are you applying under the Mutual Recognition Agreement (MRA)? Yes No If Yes, indicate the province you are coming from _____
 Mobility Provisions: Applicants currently registered with another OT regulatory organization in Canada may be eligible to apply under the Mutual Recognition Agreement (MRA). Contact the college for more information.

Registration Category Please Check One (1) only

Full Registration Provisional Registration

Citizenship

Are you a Canadian Citizen? Yes No If No, are you a permanent resident/landed immigrant of Canada? Yes No

Language Fluency

First Language	Language of O.T. Instruction
Other Languages I can practice in	

Note: If first language or language of instruction is not English, evidence of reasonable oral & written fluency is required.

OT Education Please indicate all your education experience in Occupational Therapy

<input type="text"/>	University	Prov/State/Country	Year of Graduation
<input type="text"/>	University	Prov/State/Country	Year of Graduation
<input type="text"/>	University	Prov/State/Country	Year of Graduation

10 Diploma 20 Baccalaureate 30 Master's Degree 40 Doctorate

Education other than OT Please indicate all your education experience other than Occupational Therapy

<input type="text"/>	University	Field of Study	Prov/State/Country	Year of Graduation
<input type="text"/>	University	Field of Study	Prov/State/Country	Year of Graduation

10 Diploma 20 Baccalaureate 30 Master's Degree 40 Doctorate

Exam

Have you successfully completed the CAOT Exam? Yes No

If No, date you are registered to write the CAOT Certification Exam (Provisional)

Exam Date DD / MM / YY
Exam Date DD / MM / YY

OR, I graduated from a Canadian Occupational Therapy Program before Dec. 31, 1985

Note: If you are applying for provisional registration, make sure you register with CAOT to write the first available exam. You are also required to provide a copy of the statement of candidacy letter with your application.

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Currency Hours This section must be completed each year of registration

- In the immediate past five years, I have worked at least 1000 Hours
 I completed an approved re-entry program in the past 18 months
 In the immediate past three years, I have worked at least 600 Hours
 I do NOT meet any of the above currency requirements and require a review
 I graduated within the past 18 months

NOTE: Please provide employment information, if applicable, to reflect your most recent practice hours. If additional space is required, please attach a separate page to indicate how you meet the currency hours requirement.

Employer	
Address	
Period of Employment DD / MM / YY to DD / MM / YY	Hours per Week

Employment The College is required to maintain a public register. Your name, registration status and business information may be provided upon request.

Employment Status Please Check One (1) only

- Recently been hired as an Occupational Therapist in B.C. Proposed Start Date DD / MM / YY
 Seeking Employment in British Columbia. Provide business information & employment profile when employed in B.C.
 I understand that it is my responsibility to notify the College of my employment and provide business contact information. Initial Here _____

Primary Employment

Health Authority (if applicable)	Worksite or Facility Name	
Worksite Address		
Postal Code		
Telephone	Fax	Email Address
Postal Code reflects site of practice Yes <input type="checkbox"/> No <input type="checkbox"/>		

Secondary Employment

Health Authority (if applicable)	Worksite or Facility Name	
Worksite Address		
Postal Code		
Telephone	Fax	Email Address
Postal Code reflects site of practice Yes <input type="checkbox"/> No <input type="checkbox"/>		

Third Employment

Health Authority (if applicable)	Worksite or Facility Name	
Worksite Address		
Postal Code		
Telephone	Fax	Email Address
Postal Code reflects site of practice Yes <input type="checkbox"/> No <input type="checkbox"/>		

Employment Category (indicate only one for each employment)

Primary	Secondary	Third						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Permanent	20 Temporary	30 Casual	40 Self-Employed		

Full/Part Time Status (indicate one for each employment including the average weekly hours of work)

Primary	Secondary	Third						
<input type="checkbox"/> @ _____ wk	<input type="checkbox"/> @ _____ wk	<input type="checkbox"/> @ _____ wk	10 Full-Time @ # hrs per week	20 Part-Time @ # hrs per week				

Position (indicate only one for each employment)

Primary	Secondary	Third					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Manager	30 Direct Service Provider	50 Researcher	60 Other	
			20 Professional Leader/Coordinator	40 Educator	55 Equipment Sales		

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Employment Type (indicate only one for each employment)

Primary	Secondary	Third	10 General hospital 20 Rehabilitation hospital/facility 30 Mental health hospital/facility 40 Residential care facility 50 Assisted living residence	60 Community health centre 70 Visiting agency/business 80 Group professional practice/clinic 90 Solo professional practice/clinic 100 Post-secondary education institution	110 School or school board 120 Assoc./Government/Para-Governmental 130 Industry/Manufacturing/Commercial 140 Other
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Area of Practice (indicate only one for each employment)

Primary	Secondary	Third	10 Mental Health 20 Neurological 30 Musculoskeletal 40 Cardiovascular/Respiratory 50 Digestive/Metabolic/Endocrine 60 General Physical Health	70 Vocational Rehabilitation 80 Palliative Care 90 Health Promotion/Wellness 100 Other areas of Direct Service Provision 110 Service Administration 120 Client Service Management	130 Medical/Legal related 140 Teaching 150 Research 160 Other areas of Practice
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Client Age Range (indicate only one for each employment)

Primary	Secondary	Third	10 Preschool Age (0-4) 20 School Age (5-17) 25 Mixed Paediatrics (0-17)	30 Adults (18-64) 40 Seniors (65+) 45 Mixed Adults (18-65+)	50 Other client age range
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Funding Source (indicate only one for each employment)

Primary	Secondary	Third	10 Public/Government 20 Private Sector/Individual Client	30 Public/Private Mix 40 Other funding source	45 Auto Insurance 55 Other Insurance
<input type="text"/>	<input type="text"/>	<input type="text"/>			

Professional Liability Insurance You MUST include a copy of your Insurance Certificate and/or letter from your Employer.

Provide all the information requested below.

Plan held through CAOT <input type="checkbox"/> BCSOT <input type="checkbox"/> Employer <input type="checkbox"/>	Insurance Expiry Date	Certificate Number
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Note: If you practice in both the public and private sector, you must include verification of professional liability insurance for all practice settings.

I understand it is my responsibility to maintain professional liability insurance coverage throughout my registration and I am insured for practice in all places of employment.

<input type="text"/>	Initial Here
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Professional Registration

Are you or have you ever been registered/licensed to practice as an occupational therapist in other provinces/states/countries? Yes No

If yes, provide the information below for EACH registration or license.

Note: Authorization for Release of Information/Registration in Good Standing Form(s) must be completed by each Regulatory Authority

Regulatory Body	Prov/State/Country	License/Registration No.	Expiry Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Registration in Other Professions

Are you or have you even been registered/licensed to practice in another regulated profession in British Columbia or elsewhere? Yes No

If yes, name the profession(s) _____

Provide the information below for EACH registration or license.

Regulatory Body	Prov/State/Country	License/Registration No.
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you ever had a finding of or are you currently facing a proceeding for professional misconduct, incompetency, incapacity or a similar issue in British Columbia or elsewhere? Yes No If yes, please provide details on a separate page.

Information Collection and Privacy

Information collected on this form relates to the mandate, operations and activities of the College, designated under the *Health Professions Act (HPA)* for the purpose of regulating the practice of occupational therapy in British Columbia. The College is a public body under the provisions of the *Freedom of Information and Protection of Privacy Act (FOIPPA)*. For more information or if you have any questions, please contact the Registrar.

The College promotes protection of privacy of personal information in a manner consistent with the FOIPPA. The COTBC also provides other information for national and provincial reporting for the purpose of Health Human Resource Planning. Information provided for health human resource planning is provided only in aggregate form, and personal identifiers are removed.

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Previous History and Conduct

Have you ever been refused registration in an occupational therapy regulatory body? Yes No
If yes, provide details on a separate sheet.

Have you had a finding of, or are you currently facing a proceeding for professional misconduct, competency or similar issue as an OT in another jurisdiction? Yes No

Have you ever been convicted of a criminal offence or are you currently undergoing a criminal investigation? Yes No

Is there anything else in your previous conduct that would afford reasonable grounds for the belief that you lack the knowledge, skill or judgment to practice safely and ethically? Yes No

If you have answered YES to any of the above questions, please provide full details on a separate page and enclose with your application

Declaration

I hereby make application to become registered as an Occupational Therapist with the College of Occupational Therapists of British Columbia and declare that I do not know of any reason, condition or circumstance why I should not be granted registration. I hereby certify that the information given by me in this application is true, correct and complete to the best of my knowledge and belief. I acknowledge and provide consent to the College to verify, at its discretion, any information I have provided. I understand that a false or misleading statement may result in a review of my registration or may be cause for revocation of any registration granted to me. I agree to abide by the Health Professions Act of B.C., the Occupational Therapists Regulation and Bylaws (as amended from time to time) of the College of Occupational Therapists of BC.

Signature of Applicant _____ Date _____

Signature of Witness _____ Name of Witness (please print) _____

Full Address of Witness _____ Phone No. of Witness _____

Fees

Make cheque or money order payable to COTBC. A \$25.00 fee is charged for NSF or cheques returned Not Sufficient Funds.

Application Fee _____ \$225.00

Annual Registration Fee _____ July 1 - Oct 31 (\$350) Nov 1 - Feb 28 (\$235) Mar 1 - Jun 30 (\$120)

Total Fee Included _____

Note: Check your application carefully. Incomplete applications or applications with missing documentation will delay the processing of your application for registration. It is your responsibility to ensure the application is complete.

Return the Application Form to:

The Registrar, College of Occupational Therapists of British Columbia
Suite 219, Yarrow Building, 645 Fort Street
Victoria, BC Canada V8W 1G2

Questions?

Call (250) 386-6822 Fax (250) 383-4144 Email registration@cotbc.org

For Office Use Only

Date Received _____ Fees Cheque Money Order

Application Fee \$ _____

Annual Registration Fee \$ _____ Registration Number _____