

# College of Occupational Therapists of British Columbia

## New Registrant Application Form



### Personal Information

Surname \_\_\_\_\_ Given Name(s) \_\_\_\_\_

Ms.  Mr.  Dr.  Mrs.  Miss  Previous Name(s) \_\_\_\_\_

Home Address \_\_\_\_\_

Postal Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_ Female  Male

### 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  Provisional Re-entry

### 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. Refer to codes below.

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

**Degree/Diploma Codes:** 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"/> | <input type="text"/> | University | Field of Study | <input type="text"/> | Prov/State/Country | Year of Graduation |
| <input type="text"/> | <input type="text"/> | University | Field of Study | <input type="text"/> | Prov/State/Country | Year of Graduation |

**Degree/Diploma Codes:** 10 Diploma 20 Baccalaureate 30 Master's Degree 40 Doctorate

**Field of Study Codes:**

|                                       |  |   |   |   |
|---------------------------------------|--|---|---|---|
| 010: General Rehabilitation Science   | 040: Public Health                     | 070: Psychology   | 100: Social Sciences, Arts & Humanities | 130: Business Management, Marketing & Related |
| 020: Health Administration/Management | 050: Kinesiology and Exercise Sciences | 080: Health Professions & Related Clinical Sciences       | 110: Education                          | 140: Other Field of Study                     |
| 030: Public Administration            | 060: Gerontology                       | 090: Biological & Biomedical Sciences & Physical Sciences | 120: Law                                |   |

### Exam

Have you successfully completed the CAOT Exam? Yes  No  Exam Date \_\_\_\_\_

If No, have you attempted the CAOT Exam? Yes  No  Exam Date(s) \_\_\_\_\_

Provide date you are registered to write the CAOT Certification Exam. Exam Date \_\_\_\_\_

# New Registrant Application Form

## Currency Hours This section must be completed each year of registration

- |  |  |
|--|--|
| <input type="checkbox"/> In the immediate past five years, I have worked at least 1000 Hours | <input type="checkbox"/> I completed an approved re-entry program in the past 18 months            |
| <input type="checkbox"/> In the immediate past three years, I have worked at least 600 Hours | <input type="checkbox"/> I do NOT meet any of the above currency requirements and require a review |
| <input type="checkbox"/> 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 \_\_\_\_\_ to \_\_\_\_\_ Hours per Week \_\_\_\_\_

## Employment Profile

The College is required to maintain a public register. Your name, registration status and business information may be provided upon request (Section 22 and 22.1 HPA)

## Employment Status

- |   |   |
|---|---|
| <input type="checkbox"/> <input type="checkbox"/> 10 Employed           | <input type="checkbox"/> 20 Unemployed and seeking employment in Occupational Therapy     |
| <input type="checkbox"/> <input type="checkbox"/> 15 Employed, on leave | <input type="checkbox"/> 30 Unemployed and not seeking employment in Occupational Therapy |

Recently been hired as an Occupational Therapist in B.C. Proposed Start Date \_\_\_\_\_

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 Please provide contact information for specific work site

Employer Name (Health Authority or Business Name if self-employed) \_\_\_\_\_ Worksite or Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Postal Code reflects site of practice Yes  No  Email Address \_\_\_\_\_

## Secondary Employment Please provide contact information for specific work site

Employer Name (Health Authority or Business Name if self-employed) \_\_\_\_\_ Worksite or Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Postal Code reflects site of practice Yes  No  Email Address \_\_\_\_\_

## Third Employment Please provide contact information for specific work site

Employer Name (Health Authority or Business Name if self-employed) \_\_\_\_\_ Worksite or Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Postal Code reflects site of practice Yes  No  Email Address \_\_\_\_\_

## Employment Category (indicate only one for each employment)

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

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

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

## Position (indicate only one for each employment)

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

# New Registrant Application Form

## Employment Type (indicate only one for each employment)

|  |  |  |
|--|--|--|
| Primary  | Secondary  | Third  |
| <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> |

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

## Area of Practice (indicate only one for each employment)

|  |  |  |
|--|--|--|
| Primary  | Secondary  | Third  |
| <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> |

- |   |  |  |  |
|---|--|--|--|
| <b>Direct Service—Physical Health</b><br>20 Neurological<br>30 Musculoskeletal<br>40 Cardiovascular/Respiratory<br>50 Digestive/Metabolic/Endocrine<br>60 General physical health | <b>Additional Areas of Direct Service</b><br>10 Mental Health<br>70 Vocational Rehabilitation<br>80 Palliative care<br>90 Health promotion and wellness<br>100 Other areas of direct service provision | <b>Additional Areas of Client Management</b><br>120 Client service management<br>130 Medical/Legal<br><b>Research</b><br>150 Client service management | <b>Education</b><br>140 Teaching<br><b>Administration</b><br>110 Service administration<br>160 Other areas of practice |
|---|--|--|--|

## Client Age Range (indicate only one for each employment)

|   |   |   |
|---|---|---|
| Primary   | Secondary   | Third   |
| <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> |

- |   |   |                           |
|---|---|---------------------------|
| 10 Preschool Age (0-4)<br>20 School Age (5-17)<br>25 Mixed Paediatrics (0-17) | 30 Adults (18-64)<br>40 Seniors (65+)<br>45 Mixed Adults (18-65+) | 50 Other client age range |
|---|---|---------------------------|

## Funding Source (indicate only one for each employment)

|   |   |   |
|---|---|---|
| Primary   | Secondary   | Third   |
| <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> |

- |   |  |                       |
|---|--|-----------------------|
| 10 Public/Government<br>20 Private Sector/Individual Client | 30 Public/Private Mix<br>40 Other funding source | 45 Insurance Industry |
|---|--|-----------------------|

## Professional Liability Insurance

Provide all the information requested below.

Plan held through CAOT  BCSOT  Employer  Insurance Expiry Date \_\_\_\_\_ Certificate Number \_\_\_\_\_

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. Initial Here

## 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. Attach a separate sheet if additional space is required.

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 |
|-----------------|--------------------|--------------------------|-------------|
| _____           | _____              | _____                    | _____       |
| _____           | _____              | _____                    | _____       |
| _____           | _____              | _____                    | _____       |

## 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. Attach a separate sheet if additional space is required.

|                 |                    |                          |
|-----------------|--------------------|--------------------------|
| Regulatory Body | Prov/State/Country | License/Registration No. |
| _____           | _____              | _____                    |

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.

# New Registrant Application Form

## Information Collection and Piracy

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)* and promotes protection of privacy of personal information in a manner consistent with the FOIPPA. The COTBC provides other information for national and provincial reporting for the purpose of Health Human Resource Planning. For more information or if you have any questions, please contact the Registrar.

## 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 - June 30 (\$350)  Nov 1 - June 30 (\$235)  Mar 1 - June 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](mailto:registration@cotbc.org)

### For Office Use Only

Date Received \_\_\_\_\_ Fees Cheque  Money Order

Application Fee \$ \_\_\_\_\_

Annual Registration Fee \$ \_\_\_\_\_