

College of Occupational Therapists of British Columbia

Annual Registration Renewal 2008-2009



If you require assistance completing this form please refer to the Form Guide available on our web site at: www.cotbc.org, or contact the College office.

Personal Information

Surname _____ Given Name(s) _____

Ms. Mr. Dr. Mrs. Miss Previous Name(s) _____

Address _____

Postal Code _____

Phone _____ Fax _____ Email _____

Registration Category / Change of Status Notice Please Check One (1) only

Full Registration Provisional Registration

Non-Practising. I wish to renew my registration in the non-practising category and declare that I will not be practising as an OT in BC after July 1, 2008

I wish to cancel my registration with the College and I declare that I will not be practising as an OT in BC after July 1, 2008. Sign below and return form to the College. It is your responsibility to contact the College to reinstate your registration prior to resuming practice in BC.

End date of employment _____ Signature _____

Please indicate the reason for renewing in the non-practising category or for cancelling your registration.

10 Leaving Province 20 Leave of Absence 30 Leaving Profession 40 Return to School 50 Other

Exam This section must be completed if you were registered as a provisional registrant for 2007-2008

Have you successfully completed the CAOT Exam? Yes No Exam Date _____

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

Professional Liability Insurance You are not eligible for registration renewal unless this requirement has been met.

Provide all the information requested below. You MUST include a copy of your Insurance Certificate and/or letter from your Employer.

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

Currency Hours This section must be completed each year of registration

In the immediate past five years, I have worked at least 1000 Hours

In the immediate past three years, I have worked at least 600 Hours

I graduated within the past 18 months

I completed an approved re-entry program in the past 18 months

I do NOT meet any of the above currency requirements and require a review

OT Education OT degree earned since registration for 2007-2008. Refer to degree codes below.

University _____ Prov/State/Country _____ Year of Graduation _____

University _____ Prov/State/Country _____ Year of Graduation _____

Degree/Diploma Codes: 10 Diploma 20 Baccalaureate 30 Master's Degree 31 Professional Master's 32 Research Master's 40 Doctorate

Education other than OT Refer to degree and field of study codes below.

University _____ Field of Study Prov/State/Country _____ Year of Graduation _____

University _____ Field of Study Prov/State/Country _____ Year of Graduation _____

Degree/Diploma Codes: 10 Diploma 20 Baccalaureate 30 Master's Degree 31 Professional Master's 32 Research Master's 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	

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Employment Profile

This section must be completed yearly. Registrants are responsible to notify the College & provide changes to contact information throughout the year.

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

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10 Employed
11 Employed, on leave

20 Unemployed and seeking employment in Occupational Therapy
30 Unemployed and not seeking employment in Occupational Therapy

If unemployed, you will need to provide OT employment information to the College once you begin work. Please indicate the end date for your employment.

Employment End Date _____ On leave until date _____

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 <input type="checkbox"/> <input type="checkbox"/>	Secondary <input type="checkbox"/> <input type="checkbox"/>	Third <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 <input type="checkbox"/> <input type="checkbox"/>	Secondary <input type="checkbox"/> <input type="checkbox"/>	Third <input type="checkbox"/> <input type="checkbox"/>	
@ _____ wk	@ _____ wk	@ _____ wk	10 Full-Time @ # hrs per week 20 Part-Time @ # hrs per week
If casual, provide a weekly average of your hours worked in the past 12 months. If on an approved leave, provide typical hours for your position.			

Position (indicate only one for each employment)

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

Employment Type (indicate only one for each employment)

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

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Area of Practice (indicate only one for each employment)

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

Direct Service—Physical Health
 20 Neurological
 30 Musculoskeletal
 40 Cardiovascular/Respiratory
 50 Digestive/Metabolic/Endocrine
 60 General physical health

Additional Areas of Direct Service
 10 Mental Health
 70 Vocational Rehabilitation
 80 Palliative care
 90 Health promotion and wellness
 100 Other areas of direct service provision

Additional Areas of Client Management
 120 Client service management
 130 Medical/Legal
Research
 150 Research

Education
 140 Teaching
Administration
 110 Service administration
 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="checkbox"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>

10 Preschool Age (0-4)
 20 School Age (5-17)
 21 Mixed Paediatrics (0-17)

30 Adults (18-64)
 40 Seniors (65+)
 41 Mixed Adults (18-65+)

44 All ages
 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="checkbox"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>

10 Public/Government
 20 Private Sector/Individual Client

30 Public/Private Mix
 40 Other funding source

45 Insurance Industry

Previous History and Conduct

Have you been refused registration in an occupational therapy regulatory body since July 1, 2007? Yes No
 If yes, provide details on a separate sheet.

Are you currently registered/licensed to practice as an occupational therapist in other provinces/states/countries. Yes No
 If yes, please provide the following information for all active registrations/licenses.

Regulatory Body	Prov/State/Country	Registration/License No.	Expiry Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Since July 1, 2007, have you had a finding of, or are you currently facing a proceeding for professional misconduct, competence or similar issue as an occupational therapist in another jurisdiction? Yes No

Since July 1, 2007, have you been the subject of a criminal investigation or criminal proceeding or, have you pled guilty or been convicted of a criminal offence? 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 judgement 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

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) 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.

Declaration

I hereby make application to renew my registration 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 renewal of my 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 British Columbia.

Signature of Applicant _____ Date _____

Signature of Witness _____ Date _____

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Registration Application Enclosure Checklist

Before mailing your application, check that you have included the appropriate enclosures.

- A completed, signed, dated and witnessed renewal of registration form. Be sure to complete the entire application form.
- Documentation verifying professional liability insurance coverage.
- The fee for annual registration of \$350 (may be post-dated for July 1, 2008) OR
- The fee for Non-Practising of \$75 (may be post-dated for July 1, 2008)

Registrants who are requesting a change from Provisional to Full Registration, must provide:

- Documentation of successful completion of the CAOT exam

Provisional registrants who are requesting to renew registration as a Provisional registrant, must provide:

- Documentation verifying that you are registered to write the next available sitting of the CAOT exam
- A copy of your Employer Acknowledgement Form, verifying that you are currently practising under the general supervision of a full registrant of the COTBC.

Requirement for Criminal Record Re-Check Authorization and \$20.00 Fee

- My Registration number begins with AA, AB, AC or AD
- Completed and signed Authorization for Criminal Record Check is included with my Registration Renewal form.
- The fee is included for the Criminal Record re-check. I have included a certified cheque, money order or credit card authorization payment.

Fees

Annual Registration Fee _____ \$350.00

Non-Practising Fee _____ \$75.00

Late Payment Amount _____ After July 31, 2008 - \$70.00 After August 31, 2008 - \$122.50

Total Amount Included _____

Annual Registration Fee for registration July 1, 2008 to June 30, 2009 is \$350.00. Non-practising fee is \$75.00. Annual fee for renewal of registration is due in full, on or before July 1, 2008. Your complete form and fee must be post-marked no later than July 1, 2008. Incomplete applications will delay your renewal and may result in payment of a late fee penalty.

Make cheques payable to COTBC. Cheques not post-dated to July 1, 2008 will be cashed as they are processed. A \$25.00 fee is charged for NSF or cheques returned Not sufficient funds. Duplicate receipts are provided at a cost of \$15.00.

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 Registration Renewal 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

Annual Registration Fee \$ _____