

College of Occupational Therapists of British Columbia

New Registrant Application Form



Personal Information

<input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.	Legal First Name	Middle Name	Legal Last Name
Commonly Used FIRST Name in Practice		Commonly Used LAST Name in Practice	Previous Name(s)
Home Address (Street Name, Number, Unit/Apartment)			
City	Province/Territory		Country
Postal Code	Home Phone (Landline)		Cell Phone
Email Address Required: Email is the primary method used by COTBC to communicate information essential to maintaining your registration.			Date of Birth D/ M/ Y/ <input type="checkbox"/> Female <input type="checkbox"/> Male

Work Eligibility

Please select the category that applies to you.

Canadian Citizen Yes No

Employment Authorized Under the *Immigration and Refugee Protection Act – Work Permit Expiry Date:* _____

Landed Immigrant Permanent Resident I do not yet meet this requirement

Note: You are required to provide proof that you are authorized to work in Canada in a health care profession.
If you do not currently meet this requirement, you may still begin the application process.

Labour Mobility Support Agreement

Are you applying under the Labour Mobility Support Agreement (LMSA)? 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 Labour Mobility Support Agreement (LMSA).
Contact the College for more information.

Registration Category (please check one only)

Full Registration Provisional Registration Provisional Re-entry

English Language Proficiency Requirement

First Language _____ Language of OT Instruction _____

Other Languages you can practice in _____

Note: If first language or language of instruction is not English, evidence of English proficiency is required.

OT Entry Level Education Please indicate the education you attained to enter the profession of occupational therapy

<input type="text"/>	University	Prov/State/Country	Year of Graduation
Degree/Diploma Codes: 10 Diploma 20 Baccalaureate 31 Master's (entry to profession) 41 Doctorate (entry to profession)			

OT Post Entry Level Education Please indicate any other OT education you have attained (attach a separate sheet if additional space is required)

<input type="text"/>	University	Prov/State/Country	Year of Graduation
<input type="text"/>	University	Prov/State/Country	Year of Graduation
Degree/Diploma Codes: 20 Baccalaureate 32 Master's (post entry) 40 Doctorate			

New Registrant Application Form

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

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

National Occupational Therapy Certification Examination (NOTCE) Formerly CAOT Exam

I passed the NOTCE on: Exam Date: _____

I am registered to write the NOTCE on: Exam Date: _____

I was not successful writing the NOTCE on: Exam Date: _____
(please list all attempts).

Currency Hours This section must be completed each year of registration

<input type="checkbox"/> In the immediate past three years, I have worked at least 600 hours	<input type="checkbox"/> I completed an approved re-entry program in the past 18 months
<input type="checkbox"/> I graduated within the past 18 months	<input type="checkbox"/> I do NOT meet any of the above currency requirements and require a review

Please provide employment information, if applicable, to reflect your most recent practice hours.
If 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)

<input type="text"/>	10 Employed	20 Unemployed and seeking employment in Occupational Therapy
<input type="text"/>	11 Employed, on leave	30 Unemployed and not seeking employment in Occupational Therapy

Recently been hired as an Occupational Therapist in BC Proposed Start Date _____

Seeking Employment in British Columbia. Provide business information and 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

This question needs to be answered by ALL categories of registrants.

Please indicate the primary REGION in which you will be working (or seeking work) in BC.

<input type="text"/>	10 Vancouver Island and Gulf Islands	40 Sunshine Coast/Whistler	70 Cariboo & Chilcotin Coast
	20 Metro Vancouver	50 Thompson Okanagan	80 Northern BC
	30 Fraser Valley	60 Kootenay Rockies	90 I currently work outside BC

Primary Employment Information in BC Please provide contact information for specific work site in BC

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

Address _____

Postal Code _____

Telephone _____ Postal Code reflects site of practice Yes No

Secondary Employment Information in BC Please provide contact information for specific work site in BC

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

Address _____

Postal Code _____

Telephone _____ Postal Code reflects site of practice Yes No

New Registrant Application Form

Third Employment Information in BC Please provide contact information for specific work site in BC

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

Address _____

Postal Code _____

Telephone _____ Postal Code reflects site of practice Yes No

Employment Category (indicate only one for each employment)

Primary <input type="text"/> <input type="text"/>	Secondary <input type="text"/> <input type="text"/>	Third <input type="text"/> <input type="text"/>	10 Permanent	20 Temporary	30 Casual	40 Self-Employed
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Full/Part-Time Status (indicate one for each employment including the average weekly hours of work)

Primary <input type="text"/> <input type="text"/>	@ _____ wk	Secondary <input type="text"/> <input type="text"/>	@ _____ wk	Third <input type="text"/> <input type="text"/>	@ _____ wk	10 Full-Time @ # hrs per week	20 Part-Time @ # hrs per week
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Position (indicate only one for each employment)

Primary <input type="text"/> <input type="text"/>	Secondary <input type="text"/> <input type="text"/>	Third <input type="text"/> <input type="text"/>	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="text"/> <input type="text"/> <input type="text"/>	Secondary <input type="text"/> <input type="text"/> <input type="text"/>	Third <input type="text"/> <input type="text"/> <input type="text"/>	10 General Hospital	80 Group Professional Practice/Clinic
			20 Rehabilitation Hospital/Facility	90 Solo Professional Practice/Clinic
			30 Mental Health Hospital/Facility	100 Post-Secondary Education Institution
			40 Residential Care Facility	110 School or School Board
			50 Assisted Living Residence	120 Assoc./Government/Para-Governmental
			60 Community Health Centre	130 Industry/Manufacturing/Commercial
			70 Visiting Agency/Business	140 Other

Area of Practice (indicate only one for each employment)

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

Client Age Range (indicate only one for each employment)

Primary <input type="text"/> <input type="text"/>	Secondary <input type="text"/> <input type="text"/>	Third <input type="text"/> <input type="text"/>	10 Preschool Age (0-4)	30 Adults (18-64)	44 All Ages
			20 School Age (5-17)	40 Seniors (65+)	50 Other Client Age Range
			21 Mixed Paediatrics (0-17)	41 Mixed Adults (18-65+)	

Funding Source (indicate only one for each employment)

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

New Registrant Application Form

Professional Liability Insurance

Provide all the information requested below. You must provide a copy of your insurance certificate and/or letter from your employer.

Plan held through CAOT AON 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. If you do not have professional liability insurance, you do not meet the requirements and are not eligible for registration until this mandatory requirement has been met.

I understand it is my responsibility to maintain professional liability insurance coverage throughout my registration and I am insured for practice in all public and private places of employment. I understand that false or misleading statements concerning my coverage contravene College Bylaws and are grounds for a complaint of professional misconduct. Initial Here

Professional Registration

Are you or have you ever been registered/licenced 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OT Practice History

Country where you *first* practiced OT _____

Province/territory/state where you *first* practiced OT _____

Year you *first* practiced OT _____

Country where you practiced OT most recently _____

Province/territory/state outside of BC where you practiced OT most recently _____

Most recent year of practice outside of BC _____

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	Licence/Registration No.	Expiry Date
_____	_____	_____	_____

Previous History and Conduct

If you answer YES to any of the following questions, please provide full details on a separate page and enclose with your application.

Have you ever been refused registration in an occupational therapy regulatory body? Yes No

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

Have you ever had a finding of, or are you currently facing a proceeding for professional misconduct, incompetence, incapacity or a similar issue in British Columbia or elsewhere? Yes No

Have you ever been the subject of a criminal investigation or criminal proceeding or, have you pleaded 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 judgment to practice safely, competently and ethically? Yes No

New Registrant Application Form

Information Collection and Privacy

Consent to release my email address for the purpose of recruitment to research studies. By selecting Yes, I have authorized COTBC to release my email address to Canadian-based researchers who are conducting research relevant to the practice of occupational therapy practice in Canada and have made a specific request to COTBC outlining the purpose of the research and indicated that it has received ethics approval by a recognized review board. Consenting to the release of your email **does not** imply consent to participate in the research.

Yes No

Information collected on this form relates to the mandate, operations and activities of the College as 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 information for national and provincial reporting for the purpose of health human resource planning. Information on the public register is also provided for participation in the Ministry of Health Provider Registry System.

Other Information

COTBC, along with other BC health profession regulators is collecting information on participation of registrants in the San'yas Indigenous Cultural Safety Training (ICCT) – Core Health (formerly the Indigenous Cultural Competency Training (ICC Training) offered by Provincial Health Services Authority of BC.

Have you completed the San'yas Indigenous Cultural Safety Training – Core Health offered by Provincial Health Services Authority of BC? Yes No

OR I am not aware of the ICCT Program.

Declaration

Initial Here

I hereby make application to become registered as an Occupational Therapist with the College of Occupational Therapists of British Columbia (COTBC) and declare that I do not know of any reason, condition or circumstance why I should not be granted registration.

I declare that I am in possession of valid professional liability insurance for the practice of occupational therapy in British Columbia that affords me no less than \$5 million per occurrence insuring against liability arising from an error.

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 of Occupational Therapists of British Columbia 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, revocation of any registration granted to me, or other regulatory action.

I agree to abide by the *Health Professions Act* of BC, 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 _____ 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 cheques returned indicating Not Sufficient Funds (NSF).

Application Fee _____ \$325.00

Annual Registration Fee _____ July 1 - June 30 (\$525.00) Nov 1 - June 30 (\$350.00) Mar 1 - June 30 (\$175.00)

Total Fees Included _____

Registration Fees: The application fee is \$325.00. The annual registration fee is \$525.00 and is pro-rated to \$350.00 on November 1st. and \$175.00 on March 1st.

Payment: Make cheques or money orders payable to COTBC. A \$25.00 fee is charged for cheques returned NSF (not sufficient funds). Duplicate receipts are provided at a cost of \$15.00.

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

New Registrant Application Form

Return the Registration Application Form to:

The Registrar, College of Occupational Therapists of British Columbia
Suite 402-3795 Carey Road,
Victoria, BC Canada V8Z 6T8

Questions? Call (250) 386-6822 Toll free in BC (866) 386-6822 Fax (250) 386-6824 Email registration@cotbc.org

For Office Use Only

Date Received _____ Fees Cheque Money Order

Application Fees: _____

Annual Registration Fee: _____

Checklist

Before mailing your application, ensure you have included the required enclosures. COTBC cannot proceed with registration until all documentation is received.

Please include:

- A completed, signed, dated and witnessed New Registrant Application Form.
- Provide proof of legal work authorization in Canada. If you are a Canadian citizen a copy of your birth certificate or current passport, or Canadian Citizenship card. If you are not a Canadian citizen, evidence of landed immigrant status, permanent residency, or employment authorization under the *Canadian Immigration and Refugee Protection Act, 2001* is required. Forwarding a photocopy of the document is sufficient. If you do not currently meet this requirement, you may still begin the application process.
- Documentation or a written statement from you verifying that your official transcript(s) will be forwarded to COTBC directly from the educational institution.
- Documentation of successful completion of the National Occupational Therapy Certification Exam (NOTCE) – formerly CAOT Exam, unless graduation from a Canadian program prior to December 31, 1985.

Or

- Verification that you are registered to sit the next National Occupational Therapy Certification Examination (NOTCE).
- Documentation verifying professional liability insurance coverage no less than \$5 million per occurrence.
- Criminal Record Check Requirement: Please see the Criminal Record Check Instruction Guide for more information.
- Copies of each signed Authorization for Release of Information Form(s) verifying that a form has/have been sent directly to the jurisdiction(s) where you are/or were registered to practice.
- The application fee of \$325.00. To initiate the application process you can submit only the application fee and send the registration fee at a later date.
- The annual registration fee (or pro-rated portion).

You may also need to include:

- Employer Acknowledgement Form (only if you are applying for Provisional Registration).
- Documentation of English language proficiency (only if English is not your first language or if English was not your language of OT instruction).
- Copy of the Labour Mobility Support Agreement (LMSA) form and the Authorization for Release of Information Form sent to originating Occupational Therapy Regulatory Authority (*if you are applying under the Labour Mobility Support Agreement - LMSA). Please contact the originating regulatory organization to inquire if there is a fee for completion of the LMSA Confirmation Form.