College of Occupational Therapists of British Columbia

New Registrant Application Form

Personal Information

☐ Ms. ☐ Mrs. ☐ Miss ☐ Mr. ☐ 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/

☐ Female ☐ Male ☐ Other

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

☐☐ 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)

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

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

Degree/Diploma Codes: **20** Baccalaureate **32** Master's (post entry) **40** Doctorate

Education other than OT

Please indicate all your education experience other than Occupational Therapy

	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 **40** Doctorate

Field of Study

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

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: (please list all attempts). Exam Date: _____

Currency Hours

This section must be completed each year of registration

☐ 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

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*)

10 Employed
11 Employed, on leave
20 Unemployed and seeking employment in Occupational Therapy
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.

10 Vancouver Island and Gulf Islands
20 Metro Vancouver
30 Fraser Valley
40 Sunshine Coast/Whistler
50 Thompson Okanagan
60 Kootenay Rockies
70 Cariboo & Chilcotin Coast
80 Northern BC
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

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 ☐☐ Secondary ☐☐ Third ☐☐

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 ☐☐ @ _____ wk Secondary ☐☐ @ _____ wk Third ☐☐ @ _____ wk

10 Full-Time @ # hrs per week **20** Part-Time @ # hrs per week

Position

(indicate only one for each employment)

Primary ☐☐ Secondary ☐☐ Third ☐☐

10 Manager
20 Professional Leader/Coordinator
30 Direct Service Provider
40 Educator
50 Researcher
60 Other

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

Area of Practice

(indicate only one for each employment)

Primary ☐☐☐ Secondary ☐☐☐ Third ☐☐☐

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 & 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 ☐☐

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 ☐☐

10 Public/Government
20 Private Sector/Individual Client
30 Public/Private Mix
40 Other funding source
45 Insurance Industry
55 Other Insurance

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: Regulatory History/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

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.

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 Regulatory History 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 Regulatory History 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.