

INSTRUCTIONS

This application form is for former registrants who wish to reinstate to the registry as a non-practising registrant in accordance to section 58 of the [Bylaws](#).

Before completing this application form, please carefully read the details of Reinstatement at the College's website <http://www.ctcma.bc.ca/registration/reinstatement/>

Prepare the following for submission:

1. This application form & fee
2. Photocopy of a Government issued Photo ID
3. Photo affixes to the form
4. Criminal Record Check (CRC) by the Criminal Records Review Program (CRRP)
5. A brief summary on activities you have conducted during the de-registered period (please print your name, sign and date)

Mail or deliver this application to the College at 1664 West 8th Avenue, Vancouver, BC, Canada V6J 1V4.

1. PERSONAL INFORMATION

Legal Last Name	Legal First Name	Legal Middle Name
Previous Last Name <i>(only if different with legal name)</i>	Previous First Name <i>(only if different with legal name)</i>	Previous Middle Name <i>(only if different with legal name)</i>
CTCMA Registration Number	Date of Birth (MM/DD/YYYY)	Informal Name <i>(if applicable)</i>

2. MANDATORY BUSINESS / CLINIC CONTACT

CTCMA is required to maintain a register of ALL registrants by the *Health Professions Act (sections 21/22)*. CTCMA must release the following information to the public: Registrant's name, business/clinic address, telephone number and any terms or limitations imposed by the College. This also applies to non-practising registrants.

If you leave this section blank, your home contact will be deemed as your Mandatory Business/Clinic Contact.

Business / Clinic Name <i>(if applicable)</i> :			Tel:
Business / Clinic Address:			City:
Province:	Postal Code:	Country:	Email:

3. HOME CONTACT

Home Address:			City:
Province:	Postal Code:	Country:	Email:
Tel:	Cell:	Fax:	

4. MANDATORY MAILING ADDRESS

If you left this section blank or indicated both addresses, your Mandatory Business/Clinic Contact will be deemed as your Mailing Address.

Select one only. Business / Clinic Address Home Address

5. PHOTOGRAPHS AND IDENTIFICATION

5(a) Enclose a clear photocopy of a Government issued Photo ID, i.e. a Driver license, BC Services Card, BCID, etc.

Please affix one recent photo here.

(1½" W X 2" H)

5(b) One photograph affixed to this form

- taken within the last twelve months;
- taken straight on with the face and shoulders centered and squared to the camera

Not actual size.
Refer to Measurements above.

6. FEE

\$50 Application fee (Non-Refundable) in Canadian funds are payable by:

- Credit Card – complete the attached Credit Card Pre-Authorization form
- Money Order – payable to "CTCMA"; print your name and registration number on the front of it and clip to this form

For Office Use: Total payment: \$ _____ by Visa MasterCard Money Order

7. CRIMINAL RECORD CHECK BY CRIMINAL RECORDS REVIEW PROGRAM

Criminal Record Check (CRC) by the Criminal Records Review Program (CRRP) for CTCMA - Details at www.ctcma.bc.ca

- I have completed my Criminal Record Check and my CRC Service number is _____
- I previously completed my Criminal Record Check and my clearance letter is valid till _____ (mm/dd/yyyy)
(Former registrants may find their CRC expiry date online through CTCMA Member Portal at <https://portal.ctcma.bc.ca/>)

8. TERMS AND CONDITIONS

- It is the responsibility of the applicant to complete this application form accurately and include all documents and fees. The applicant must complete the application process personally.
- It is the responsibility of the applicant to read the *Health Professions Act (BC)* and the CTCMA Bylaws to understand the registration requirements and the statutory responsibilities of a regulated health professional.
- This application is valid for 3 months from the date of applicant's signature.

9. APPLICANT'S DECLARATION

I, _____, declare that all the information and statements made in or submitted with this application are true, complete and correct, and I make this declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath. I also understand that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of registration.

Signature of Applicant:

Date:

The personal information requested on this form is collected under the authority of, and will be used for, the purpose of administering the registration process under the *Health Professions Act*, TCMPA Regulation and CTCMA Bylaws. The collection, use and disclosure of personal information are subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use or disclosure of this information, please contact the Privacy Officer.



INSTRUCTIONS

The form must be signed and dated; all information must be complete for your application to proceed. Incomplete forms will be voided. Credit card information should not be emailed.

Mail or deliver the application and this form together to the College at:

- 1664 West 8th Avenue, Vancouver, BC, Canada V6J 1V4.

APPLICANT INFORMATION

Legal First Name	Legal Last Name	CTCMA Registration Number
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REGISTRATION REINSTATEMENT FEES

Application fee for Registration Reinstatement as Non-Practising Registrant: \$50 in Canadian funds.

CREDIT CARD INFORMATION

Card Type: Visa MasterCard

Name as it appears on card	Card Number	Date of Expiry	
		Month	Year
Authorization I authorize the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC to charge \$50 to my credit card.	Signature of Cardholder	Date	
		Year	Month Day