



## Naturopathic Medicine Application – Certification Course Approval

**Privacy and Security**

The College collects personal information in accordance with the requirements of Section 26 of the *Freedom of Information and Protection of Privacy Act*. As per Section 30 of the Act, the College takes reasonable measures to protect this information and provide security against risks such as unauthorized use, disclosure, or disposal.

**IMPORTANT:** The College reviews applications in the order in which they are received. You will be notified in writing of the outcome of your application.

COURSE PROVIDER INFORMATION		
Organization Name		
Name of contact person submitting the application		
Address		
City/Town	Prov./Terr.	Postal Code
Telephone (     )	Email Address	
Fax (     )	Website	



## COURSE INFORMATION

What certification will this course teach? (e.g. – IV, Chelation, Advanced Injections Part A, etc.)

Name of course  
(As appears on the certificate)

Date(s) the course will be offered

Location of the course

Is the course offered in person or online?  
(Provide as much detail as possible, attach a separate document if needed)

### Time Allocations

Practical / Hands-on Hours	Didactic / Theoretical Hours	Total Number of Course Hours

### Course Delivery Format

<input type="checkbox"/> <b>In person</b> (Participants practice with one another, with instructor guidance)	<b>Ratio of instructor(s) to participants</b>
<input type="checkbox"/> <b>In person - Group</b> (Participants are taught in a group, led by an instructor)	<b>Ratio of instructor(s) to participants</b>
<input type="checkbox"/> <b>Lecture</b>	
<input type="checkbox"/> <b>Paced online course</b> (Completion of modules required to progress)	



<input type="checkbox"/> <b>Interactive webinar with the course provider and participants</b>		
<input type="checkbox"/> <b>DVD or books, with a home study guide</b>		
<input type="checkbox"/> <b>Other</b> <i>(Please specify and provide details. Attach a separate page with additional information if needed)</i>		
<b>Method of Attendance Verification</b>		
<input type="checkbox"/> <b>Sign-in sheet</b>	<input type="checkbox"/> For each day	<input type="checkbox"/> For each session
<b>Method of Assessment</b>		
<input type="checkbox"/> <b>Quiz questions</b>	<input type="checkbox"/> <b>Scenarios (role-playing)</b>	
<i>(For any content that is not in person, at least 5 questions are required for each 1.0 hour of education. Attach copies of Quiz Questions with this application)</i>		

Please attach details/supporting documents to satisfy the following:

1. Format (e.g. course, conference or seminar, in person, live webinar, recorded video);
2. Number of hours allocated to each of didactic/theoretical and practical/hands-on training, and
3. Method of attendance verification (e.g. sign-in sheet for day, for each session; quiz questions for sessions attended online or by video).

Confirm the following supporting documentation is enclosed with this application:

- Content overview: detailed course outline and/or agenda (**required**), and any additional materials (if available); and
- Sample certificate. Please include name of provider; name of course, conference or seminar; name of participant; total number of hours attended; date of successful completion; and name of course instructor(s); and
- Copy of the course examination.

**PLEASE SUBMIT ALL DOCUMENTATION IN PDF FORM AND WHERE POSSIBLE, AS ONE PDF DOCUMENT.**



## INSTRUCTOR INFORMATION

(Attach completed copies of this page for each instructor that will be teaching the course, along with supporting documentation)

Name of instructor

Qualifications *(Enclose curriculum vitae)*

Professional registration *(Include licence number and full name of regulatory body):*

Confirm the following supporting documentation is enclosed:

Curriculum vitae



## Previously Approved Certification Courses

List any courses offered by the organization that have previously obtained College approval, and the date (or approximate date) when the approval was issued.

Course Name	Date Approved



## APPLICANT ATTESTATION (required):

I, \_\_\_\_\_,  
*Name of Course Provider Representative*

on behalf of \_\_\_\_\_, declare that:  
*Course Provider/Organization offering the course*

All course instructors have the appropriate credentials for providing this education, including being licensed and/or certified, and having <b>at least 5 years of clinical experience</b> performing the procedures and/or treatments, in the aspect of practice in which they are educating attendees.	<input type="checkbox"/> Yes <input type="checkbox"/> No
All course instructors have completed a course in at least one of the following: Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or Naturopathic Advanced Life Support (NALS) within the past two years.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attendees of the course who have satisfied the competency criteria will receive a certificate of course completion, a sample copy of which is included in this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I consent to all legitimate and reasonable uses of the information contained within this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
The course provider maintains professional liability insurance with a limit of liability not less than <b>\$3,000,000 per occurrence</b> insuring against liability arising from an error, omission, or negligent act of the course provider, its instructors, and course participants.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I will provide the College with a current version of the course outline (syllabus) and examination on an <b>annual basis</b> .	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>I certify that the information contained in this application is true, complete, and accurate to the best of my knowledge. Additionally, I will notify the College of any future changes to the information contained in this application, and if I wish the course to be approved in future years.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date (yyyy/mm/dd)*



## INFORMATION FOR SUBMITTING THIS FORM:

**Sign and return the form to the College of Complementary Health Professionals of British Columbia.**

**By email:** [QAprograms@cchpbc.ca](mailto:QAprograms@cchpbc.ca)

**By mail:** 900 – 200 Granville Street, Vancouver BC V6C 1S4

**By fax:** 604-608-9726

If you have any questions regarding this process, please contact the College at 604-742-6670 or [QAprograms@cchpbc.ca](mailto:QAprograms@cchpbc.ca).