College of
COMPLEMENTARY HEALTH
PROFESSIONALS OF BC

Naturopathic Medicine Application - Continuing Education Courses

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	

CONTINUING EDUCATION COURSE INFORMATION

Which continuing education course category are you applying for and how many hours in that category? *(Please see continuing education course categories listed on the Naturopathic Physicians – Registrant Practice Resources page under 'Quality Assurance Program'.)*

Name of course
(As appears on the certificate)

Location of the course

Is the course offered in person or online?
(Provide as much detail as possible)

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

Course Delivery Format	
☐ **In person** *(Participants practice with one another, with instructor guidance)*	***Ratio of instructor(s) to participants***
☐ **In person - Group** *(Participants are taught in a group, led by an instructor)*	***Ratio of instructor(s) to participants***
☐ **Lecture**	
☐ **Online Course/Webinar – Live with no provider and participant interaction**	

☐ **Online Course/Webinar – Live interactive webinar with the course provider and participants**		
☐ **DVD or books, with a home study guide**		
☐ **Conference** *(Indicate if it's a live in-person conference or online)*		
☐ **Other** *(Please specify and provide details. Attach a separate page with additional information if needed)*		
Method of Attendance Verification		
☐ **Sign-in sheet**	☐ For each day	☐ For each session
Does the Course include an Assessment?		
☐ **Quiz questions** *(For any content that is not in person, at least 5 questions for each 1.0 hour of education)*	☐ **Scenarios (role-playing)**	

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, specifically, how many hours apply to Prescriptive Authority if applicable; 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:

☐ 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, 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 Continuing Education 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 **at least 5 years of experience** performing the procedures and/or treatments, in the aspect of practice in which they are educating attendees.	☐ Yes ☐ No
If the course **includes demonstration or practice on live patients** (including course participants), all instructors for the course 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.	☐ Yes ☐ No ☐ N/A
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.	☐ Yes ☐ No
I consent to all legitimate and reasonable uses of the information contained within this application.	☐ Yes ☐ No
If the course includes demonstration or practice on live patients (including course participants), the course provider maintains professional liability insurance with a limit of liability not less than **$3,000,000 per occurrence** insuring against liability arising from an error, omission, or negligent act of the course provider, its instructors, and course participants during the course.	☐ Yes ☐ No ☐ N/A
Following approval from the Quality Assurance Committee, if the course has any substantial changes, you agree you will provide the College with an updated version ofthe course outline (syllabus) and examination. (N/A for courses offered one time only)	☐ Yes ☐ No ☐ N/A
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.	☐ Yes ☐ 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
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.