College of
COMPLEMENTARY HEALTH
PROFESSIONALS OF BC

# REGISTRATION CANCELLATION REQUEST FORM for Full / Non-Practising Registrants

*For Registrants in the Traditional Chinese Medicine and Acupuncture Profession*

| PERSONAL INFORMATION | | |
|---|---|---|
| **Legal Last Name** | **Legal First Name** | **Legal Middle Name** |
| **CTCMA Registration Number** | **Date of Birth** (MM/DD/YYYY) | **Informal Name** *(if applicable)* |

## REGISTRANT'S DECLARATION

**I, _____ (Registrant's Full Legal Name) _____ (Registration #) am registered with the College as a Full registrant (R.Ac. / R.TCM.H. / R.TCM.P. / Dr.TCM.) or a Non-Practising registrant. By signing this application form, I request the College to cancel my registration immediately and I declare that I will not practice anywhere in British Columbia, Canada within the scope of practice as defined in Section 4 of the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation (Health Professions Act BC).**

**I will follow the Practice Standard - Clinical Record Keeping to take reasonable steps to give appropriate notification of the practice closure to each patient for whom I have primarily responsibility. I will assist the transfer of patient care to another provider.**

**After my practice closure, (please select one):**

◯ I keep the patient records in my possession securely at the following location:

_____

_____

Patient(s) can contact me to arrange to receive a copy of their records (possibly with a fee) by the following methods:

In Writing: Address at above _____

*Or* write to the following address:

_____

_____

Telephone: _____

Email: _____

I will notify the College when any of the above contact information has changed. It is my professional responsibility to keep the files for at least a specific period (10 years since last record entry or in the case of minors, 10 years from the time the patient would have reached the age of majority (age 19 years in BC)).

◯ I transfer my patient records to the following custodian:

Name of custodian: _____

Custodian Address: _____

Custodian Email: _____

Custodian Telephone: _____

Custodian's Health Professional Title: _____

Name of Regulatory Body the Custodian register with: _____

Name of company (optional): _____

Custodian's position in company (optional): _____

Company telephone (optional): _____

Company Email (optional): _____

***THIS PART IS FOR CUSTODIAN TO COMPLETE***

I as the custodian is aware of the legal requirements of the College to keep the files for at least a specific period (10 years since last record entry or in the case of minors, 10 years from the time the patient would have reached the age of majority (age 19 years in BC)) and agrees to do so in a secured and confidential manner.

I will notify the College if the patient records are moved or transferred to another location or custodian.

Signature of custodian: _____

Signature Date: _____

| Signature of Applicant (MUST match signature in official IDs): | Date: |
|---|---|
| | |

- Please ensure fully complete and sign this form before submitting to the College.
- Keep a copy of this request form for your file. NO document will be returned to you.
- Registrants may submit this request form to the College by email in PDF form to College at **registration@cchpbc.ca**
- Registration fee is non-refundable.