College of Homeopaths of Ontario
163 Queen Street East, 4th Floor, Toronto, Ontario, M5A 1S1
TEL 416-862-4780 OR 1-844-862-4780
FAX 416-874-4077
www.collegeofhomeopaths.on.ca

Form A

Office Use Only	
Date Received:	
Staff Reviewer:	
Application Number:	

Application for Registration in the Full Class (for eligible individuals)

College of Homeopaths of Ontario (CHO)

Prior to completing this application form, please read the *Application Guide* for detailed instructions. This form is a legal document. Please print clearly.

SECTION 1: PERSONAL INFORMATION

A. Current Legal Name

Legal First Name	Legal Middle Name(s)	Legal Last Name

Yes	No	
		Have you been known by any other name(s)? (*If you answer "yes," complete the section regarding your previous name(s) below. If you answer "no," then proceed to question 1.c)*

B. Previous Legal Name(s)

Previous First Name	Previous Middle Name(s)	Previous Last Name

	Year	Month	Day		Year	Month	Day
Start Date:				**End Date:**			

Previous First Name	Previous Middle Name(s)	Previous Last Name

	Year	Month	Day		Year	Month	Day
Start Date:				**End Date:**			

Previous First Name	Previous Middle Name(s)	Previous Last Name

	Year	Month	Day		Year	Month	Day
Start Date:				**End Date:**			

C. Alternate Name

Yes	No	
		Is there a nickname or abbreviation of your name that you practice under and would like included in the Public Register? (*If you answer "yes," indicate your alternate name below. If you answer "no," then proceed to question 1.d)*

Alternate Name:	

	Year	Month	Day		Female	Male		English	French
D. Date of Birth:				**E. Sex:**			**F. Preferred Language:**		

G. Identity Documentation

*Applicants are required to submit one notarized photocopy of a government-issued ID verifying **each** legal name declared above.*

Document Type	Document Number	Date of Expiry *(if applicable)*	Name as it Appears on Document

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SECTION 2.A: CONTACT INFORMATION – RESIDENCE

Street Number and Name *(Required)*			Unit / Suite Number
City *(Required)*	Province *(Required)*	Country *(Required)*	Postal Code *(Required)*
Telephone *(Required)*	Fax	Email *(Required)*	

SECTION 2.B: CONTACT INFORMATION – BUSINESS LOCATIONS

Business Name 1: *(if applicable)*	

Street Number and Name *(Required)*			Unit / Suite Number
City *(Required)*	Province *(Required)*	Country *(Required)*	Postal Code *(Required)*
Telephone *(Required)*	Fax	Email *(Required)*	

Business Name 2: *(if applicable)*	

Street Number and Name			Unit / Suite Number
City	Province	Country	Postal Code
Telephone	Fax	Email	

Business Name 3: *(if applicable)*	

Street Number and Name			Unit / Suite Number
City	Province	Country	Postal Code
Telephone	Fax	Email	

SECTION 2.C: PREFERRED CONTACT

Preferred address for communication with the CHO *(Check one)*:	Residence	Business 1	Business 2	Business 3

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SECTION 3.A: EDUCATION RELATED TO HOMEOPATHY

Yes	No	
		I hold a homeopathic certification issued by a professional homeopathic organization or association.
Certification held with:		
Yes	No	I have successfully completed formal education in the practice of homeopathy. *(If you answer "yes," complete the **entire** section below. If you answer "no," then proceed to Section 3.c)*

Highest level of education related to homeopathy completed *(Check one)*:		Diploma		Master		Professional Doctorate
		Baccalaureate		Doctorate		Other
Type of institution where you received this education *(Check one)*:		Canadian Career College		Outside Canada		Canadian College/University

PROGRAM 1 Educational Institution Name:							
Educational Institution Address				Degree / Diploma Name			
Start Date:	Year	Month	Day	**Graduation Date:**	Year	Month	Day

PROGRAM 2 *(if applicable)* **Educational Institution Name:**							
Educational Institution Address				Degree / Diploma Name			
Start Date:	Year	Month	Day	**Graduation Date:**	Year	Month	Day

PROGRAM 3 *(if applicable)* **Educational Institution Name:**							
Educational Institution Address				Degree / Diploma Name			
Start Date:	Year	Month	Day	**Graduation Date:**	Year	Month	Day

SECTION 3.B: CLINICAL HOMEOPATHY EXPERIENCE

Total Number of Weeks of Clinical Experience Program:	_____ weeks	**Total Number of Hours of Direct Client Contact in Clinical Experience Program:**	_____ hours

	Year	Month	Day
I successfully completed my clinical experience program on this date:			

☐ I have submitted **Form B** directly to each Educational Institution related to homeopathy that I attended. I understand that my application is not complete until the College has received **Form B** and **official transcripts**. ***I understand that further documentation may be required.***

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SECTION 3.C: EDUCATION UNRELATED TO HOMEOPATHY

Yes	No	
		I have successfully completed formal education in a field of study unrelated to homeopathy. *(If you answer "yes," complete the **entire** section below. If you answer "no," then proceed to Section 4.)*

Highest level of education unrelated to homeopathy completed *(Check one)*:		Diploma		Master		Professional Doctorate
		Baccalaureate		Doctorate		Other
Type of institution where you received this education *(Check one)*:		Canadian Career College		Outside Canada		Canadian College/University

Field of study for highest level of education completed that was unrelated to homeopathy *(Check one)*:

	Biological and Biomedical Sciences		Health Administration/Management		Physical Sciences
	Business, Management, Marketing and Related		Health Professions/Related Clinical Science		Psychology
	Education		Kinesiology and Exercise Science		Public Administration
	Engineering		Law		Public Health
	Gerontology		Mathematics, Computer Sciences		Social Sciences, Arts and Humanities
	General Rehabilitation Science		Medical Laboratory Science		Other

Country of Institution:		**Province/State** *(if Canada or USA)*:		**Year of Graduation:**	
Name of Educational Institution:					

SECTION 4: CURRENCY

Check one	**Demonstration of Currency**
	It has been more than 12 months since I completed my homeopathy education and/or clinical experience program. (*If box is checked, complete Sections 4.a) and 4.b) below.*)
	It has been less than 12 months since I completed my homeopathy education and/or clinical experience program. (*If box is checked, proceed to Section 5.)*

	Year	Month		Year	Month
Start Date of 3-Year Period:			**End Date of 3-Year Period:**		

A. Clinical Experience Hours in the 3-Year Period Immediately Prior to Application

Calendar Year	**Intake Hours** *(2 hours accepted per visit)*	**Follow-up Hours** *(1 hour accepted per visit)*	**Total Hours**
		Total Number of Clinical Experience Hours:	

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B. Non-Clinical Experience Hours in the 3-Year Period Immediately Prior to Application *(Attach additional sheets, if needed.)*

Calendar Year	Type of Experience *(According to policy REG CS 04)*	Total Hours
	Total Number of Non-Clinical Experience Hours:	

SECTION 5: PREVIOUS PRACTICE

Yes	No	
		Have you previously practiced homeopathy? (*If you answer "yes," complete **all** questions below. If you answer "no," then proceed to Section 6.*)

A. Country in which you first practiced homeopathy:	
B. Year in which you first practiced homeopathy:	
C. Year in which you first practiced homeopathy in Canada:	

D. If the country in which you first practiced homeopathy was Canada or the USA, indicate the province, territory or state:

	Alberta		British Columbia		Manitoba		New Brunswick	Newfoundland
	Nova Scotia		Northwest Territories		Nunavut		Ontario	Prince Edward Island
	Quebec		Saskatchewan		Yukon		USA, state:	

E. If the country in which you first practiced homeopathy was not Canada, indicate the first Canadian location of practice:

	Alberta		British Columbia		Manitoba		New Brunswick	Newfoundland
	Nova Scotia		Northwest Territories		Nunavut		Ontario	Prince Edward Island
	Quebec		Saskatchewan		Yukon		*Not applicable*	

F. Country in which you most recently practiced homeopathy:	

G. If the country in which you most recently practiced homeopathy was Canada or the USA, indicate the province, territory or state:

	Alberta		British Columbia		Manitoba		New Brunswick	Newfoundland
	Nova Scotia		Northwest Territories		Nunavut		Ontario	Prince Edward Island
	Quebec		Saskatchewan		Yukon		USA, state:	

H. Year in which you most recently practiced homeopathy:	

SECTION 6: INDIVIDUAL ASSESSMENT

	Year	Month	Day
I have successfully completed the Individual Assessment on this date:			

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SECTION 7: JURISPRUDENCE

	Year	Month	Day
I have successfully completed the CHO Jurisprudence Course on this date:			

SECTION 8: STANDARD FIRST AID & HEALTHCARE PROVIDER CPR

	Year	Month	Day
A. I have successfully completed a Standard First Aid course on this date:			

	Year	Month	Day
B. I have successfully completed a Healthcare Provider (HCP) CPR course on this date:			

SECTION 9: LANGUAGE FLUENCY

Check one	**A. Demonstration of Fluency in English or French**
	I declare either English or French as my first language and I am able to speak, read and write it with reasonable fluency so as to provide homeopathic services in that language.
	I have completed a post-secondary program in homeopathy that was taught in English or French.
	I have successfully completed a Canadian Language Benchmark assessment.

B. Languages Used in Practice
Indicate all languages in which you can competently provide homeopathic services:

	English		French	Other:
Other:		Other:		Other:

SECTION 10: PROFESSIONAL LIABILITY INSURANCE

Check one	**Demonstration of Eligibility for Professional Liability Insurance**
	I declare that I am eligible for professional liability insurance coverage. (*If you do not yet have an insurance policy, continue to Section 11.*)
	I currently hold professional liability insurance covering my homeopathic practice. (*If box is checked, complete the **entire** section below.)*

Insurance Company	Brokerage Firm		Year	Month	Day
		Start Date:			
Policy Number	**Annual Aggregate Amount**		**Year**	**Month**	**Day**
		Expiry Date:			

SECTION 11: CRIMINAL BACKGROUND CHECK

	Year	Month	Day
I have completed a criminal background check based on my full legal name, all previous legal names *(if applicable)* and date of birth, on this date:			

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SECTION 12: REGULATORY HISTORY

A. List all health regulatory bodies of which you have ever been a member in any country. All affiliations must be listed.

Health Regulatory Board / Council Name	Registration No.	Country	Region

B. Disclosure of Prior Regulatory / Legal Proceedings

*Applicants are **required** to answer each of the questions below. If you answer "yes" to any of the questions listed in this section, you must supply details for each "yes" answer on a separate sheet. If a question does not apply to you, you may answer "no." For information on the details required, see the* Application Guide.

Yes	No	**In Ontario or any other jurisdiction, in relation to *any regulated profession*, are you the subject of, or have you been the subject of:**
		i. a finding of professional misconduct, incompetence or incapacity or any similar finding?
		ii. a current proceeding for professional misconduct, incompetence or incapacity, or any other similar proceeding?
		iii. a finding of professional negligence or malpractice?
Yes	No	**In Ontario or any other jurisdiction, in relation to any regulated *health* profession, have you ever:**
		iv. been refused registration or licensure?
		v. failed to pass a required registration or licensing examination?
		vi. not been in good standing with the regulatory body at the time you ceased being registered or licensed?
		vii. been non-compliant in the payment of fees to the regulating body?
		viii. been non-complaint with the obligation to provide information?
		ix. been the subject of an investigation by the regulatory body?
		x. been subject to sanctions imposed by the regulatory body?
Yes	No	**Have you ever been found guilty of:**
		xi. a criminal offence?
		xii. an offence resulting in a fine greater than $1,000 or any form of custody or detention?

C. Disclosure of Other Information

Yes	No	
		Are there any other events, circumstances, conditions or matters not disclosed above that would provide reasonable grounds for the belief that you would not practice homeopathy in a safe and professional manner?

SECTION 13: AUTHORIZATION SIGNATURE

I declare that the information contained in this application is accurate and true to the best of my knowledge.

Signature of Applicant	Date of Signature

Your application will be considered complete when all documents have been received. Completed applications are processed as expediently as possible, in the order received.

Completing this application and submitting your notarized documents for registration does not imply, in any manner, that you are registered with the CHO. Without an approved CHO Certificate of Registration you may not use the title and designation "Homeopath" and "Hom," or hold yourself out as a Homeopath in Ontario.

Please keep a photocopy of this form for your records.