Form B

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

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

Certificate of Dean or Principal of College/University Granting Diploma/Degree of Homeopathy

Applicants who are completing a Full Class application form or a pre-application to determine eligibility to register must provide the CHO of evidence of their graduation from a program in homeopathy. Applicants must complete Section 1 and send the form to their college/university of graduation. **Section 2 of this form must be completed by the Dean or Principal of the college/university in which you obtained your diploma/degree in homeopathy and mailed directly to the CHO.**

A separate form must be completed for each educational institution. Please print clearly.

Section 1

First Name: ________________________ Middle Name(s): ________________

Last Name: ________________________ Student Number: ________________

College/University of Graduation: ________________________________

College/University Address: ________________________________
Street City

____
Province Postal Code Country

I, the undersigned, authorize the educational institution listed above to provide the information requested below to the College of Homeopaths of Ontario (CHO) and any additional information requested by the CHO in order to process my application for registration.

________________________________ ________________
Signature of Applicant Date of Signature

Section 2

To be completed by the college/university of graduation and forwarded **along with an official transcript of records** directly to:

College of Homeopaths of Ontario
163 Queen Street East, 4th Floor
Toronto, Ontario M5A 1S1
Canada

Name of Graduate: ________________________________

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Name: ______________________________

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Name of Education Program: ____

Start Date of Education Program: ____

Date of Successful Completion of Education Program: __________________________

Did the education program include a structured, comprehensive, supervised and evaluated program of clinical experience? ☐ Yes ☐ No

If "yes," total number of **weeks** of clinical experience program: ________________

If "yes," total number of **hours** of direct client contact: ______________________

Name of Dean or Principal: ____

Signature of Dean or Principal: ____

Date of Signature: __________________________