



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

## Form C

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

### Certificate of Professional Conduct

Individuals who are or have been regulated by a health regulatory body other than the CHO, in Ontario or in any jurisdiction, must complete Section 1 and send this form to the appropriate health regulatory / licensing body. Section 2 of this form must be completed by the health regulatory / licensing body and mailed directly to the CHO.

A separate form must be completed for each health regulatory / licensing body. Please print clearly.

Section 1
First Name: _____ Middle Name(s): _____ Last Name: _____ Former Name(s): _____ Regulatory/Licensing Body: _____ Regulatory Body Address: _____ <div style="display: flex; justify-content: space-between;"> <span>Street</span> <span>City</span> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <span>Province</span> <span>Postal Code</span> <span>Country</span> </div> <p>I, the undersigned, authorize the regulatory/licensing body 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 registration.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Signature of Registrant / Licensee</span> <span>Date of Signature</span> </div>

Section 2
To be completed by the regulatory/licensing body and forwarded directly to: <div style="text-align: center; margin: 10px 0;"> <b>College of Homeopaths of Ontario</b>  <b>163 Queen Street East, 4th Floor</b>  <b>Toronto, Ontario M5A 1S1</b>  <b>Canada</b> </div> Name of Registrant/Licensee: _____ Registration/License No.: _____ Date of Registration: _____ Class/Type of Registration (if applicable): _____ <i>If the individual is no longer registered, please indicate the date the registration was resigned or revoked:</i> _____

(continued on page 2)



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Name: \_\_\_\_\_

Please provide the following information regarding the above mentioned registrant/licensee:

Has the registrant/licensee ever had a finding in the nature of professional misconduct, incompetency or incapacity, or a like finding made against him or her?  Yes  No

Is the registrant/licensee currently under investigation or involved in a proceedings for conduct in the nature of professional misconduct, incompetency or incapacity or any like investigation or proceeding?  Yes  No

If the answer to either question is "yes," please provide further information to the CHO.

Name of Registrar/Secretary: \_\_\_\_\_  
Print Name

I, the Registrar/Secretary, acting on behalf of the \_\_\_\_\_  
Name of Regulatory/Licensing Body

do hereby certify that the foregoing statements are true statements regarding the registration record for the above mentioned registrant/licensee.

Signature of Registrar/Secretary: \_\_\_\_\_

Date: \_\_\_\_\_



Affix seal or stamp of registration / licensing board here.