

Application Form for Advanced Competencies and Statutory Declaration



College of
Speech and Hearing
Health Professionals of BC

SECTION I

PERSONAL INFORMATION

Name:
Salutation Surname First Initial

Reserved Title(s):
(AUD /HIP / SLP)

Day Phone (area code, number):

Contact Email address:

SECTION II

ADVANCED COMPETENCIES

Check and complete all the Advanced Competencies that you are applying for.

A) VESTIBULAR ASSESSMENT AND MANAGEMENT

Please Check Here

(refer to Acceptable Program of Study Certificate A to form part of this application.)

.....
Name of Acceptable Program (refer to section 99 or 100.1(1)(a) of the College Bylaws)

.....
Program Dates Completion Date

.....
Name of Organization/Institution, Location

I hereby attest that I have met the requirements as stated in section 98(1) of the bylaws, that the program of study mentioned above meets with the requirements as listed in section 99, and that I have successfully completed *(name of exam)* on *(date completed)* as also required in section 98(1)(c).

.....
Signature of Applicant

.....
Date

B) COCHLEAR IMPLANT MANAGEMENT

Please Check Here

(refer to Acceptable Program of Study Certificate B to form part of this application.)

.....
Name of Acceptable Program (refer to section 105 or 105.1(1)(a) of the College Bylaws)

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

I hereby attest that I have met the requirements as stated in section 104(1) of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 105.

.....
Signature of Applicant

Date

C) CERUMEN MANAGEMENT

Please Check Here

(refer to Acceptable Program of Study Certificate C to form part of this application.)

.....
Name of Acceptable Program

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

I hereby attest that I have met the requirements as stated in section 108(1) of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 109.

.....
Signature of Applicant

Date

D) HEARING INSTRUMENT SERVICES FOR CHILDREN

Unavailable at this time. Regulation has been extended to April 1, 2012 whereby Hearing Instrument Practitioners who are not also Audiologists may continue to practice on children.

E) FIBEROPTIC ENDOSCOPIC EVALUATION AND MANAGEMENT OF VOICE DISORDERS

Please Check Here

(refer to Acceptable Program of Study Certificate E to form part of this application.)

.....
Name of Acceptable Program

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

I hereby attest that I have met the requirements as stated in section 116 of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 118.

.....
Signature of Applicant

Date

F) FIBEROPTIC ENDOSCOPIC EVALUATION AND MANAGEMENT OF SWALLOWING DISORDERS

Please Check Here

(refer to Acceptable Program of Study Certificate F to form part of this application.)

.....
Name of Acceptable Program

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

I hereby attest that I have met the requirements as stated in section 116 of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 121.

.....
Signature of Applicant

Date

G) VOICE RESTORATION (VOICE PROSTHESES)

Please Check Here

.....
Name of Acceptable Program (refer to Acceptable Program of Study Certificate G to form part of this application.)

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

- I hereby attest that I have met the requirements as stated in section 116 of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 124.

.....
Signature of Applicant

Date

H) VOICE RESTORATION (TRACHEOTOMY TUBES OR SPEAKING VALVES)

(refer to Acceptable Program of Study Certificate H to form part of this application.)

Please Check Here

.....
Name of Acceptable Program

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

- I hereby attest that I have met the requirements as stated in section 116 of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 127.

.....
Signature of Applicant

Date

I) VIDEOFLUOROSCOPIC ASSESSMENT OF ADULT SWALLOWING DISORDERS

(refer to Acceptable Program of Study Certificate I to form part of this application.)

Please Check Here

.....
Name of Acceptable Program

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

- I hereby attest that I have met the requirements as stated in section 116 and 129 of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 130.

.....
Signature of Applicant

Date

- I was issued a previous certificate as per section 130.4(1) and hereby request a replacement certificate.

.....
Signature of Applicant

Date

J) VIDEOFLUOROSCOPIC ASSESSMENT OF PAEDIATRIC SWALLOWING DISORDERS

(refer to Acceptable Program of Study Certificate I to form part of this application.)

Please Check Here

.....
Name of Acceptable Program

.....
Program Dates

Completion Date

.....
Name of Organization/Institution, Location

- I hereby attest that I have met the requirements as stated in section 116 and 131 of the bylaws and that the program of study mentioned above meets with the requirements as listed in section 131.1.

.....
Signature of Applicant

Date

- I do not meet the requirements as per section 116 and 131 or 131.1 of the College Bylaws, however, I do meet the requirements as per section 131.2 and therefore I sign this as a Statutory Declaration, Form #12.

.....
Signature of Applicant

Date

SECTION III

FEE SCHEDULE

Number of Advanced Competencies Applied for:

Advanced Competencies Certification Fee per Certificate

X \$ 45

Applicable Total Payment

\$ *

GST/PST is not applicable

*Note: Maximum amount payable is \$90.00 regardless of the number of advanced competencies applied for.

Please submit a cheque or money order payable to the "College of Speech and Hearing Health Professionals of BC" or CSHHPBC, in the total amount you have calculated above.

To ensure the completeness of your application, please ensure your payment is attached with this form.

Mail your application to:

College of Speech and Hearing Health Professionals of BC
410 - 999 West Broadway, Vancouver, BC V5Z 1K5