CTCMA

REQUEST FOR REGISTRATION CERTIFICATE
(For Approved Initial Registration)

College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia

INSTRUCTIONS

Your registration certificate will be mailed to you upon receiving this request from you.

- Ensure your contact information is up to date (that can be reviewed/updated online through CTCMA Members Portal)
- Mail this form to the College
- Attach your outdated certificate if your registration title has been changed.
- Keep copies of all application documents for your file. NO documents will be returned to you.

PERSONAL INFORMATION

Legal Last Name	Legal First Name	Legal Middle Name (if any)
CTCMA Registration Number	Date of Birth (MM/DD/YYYY)	

REGISTRATION CERTIFICATE

Indicate the registration certificate applying for: ❒ R.Ac ❒ R.TCM.H. ❒ R.TCM.P. ❒ Dr.TCM.

DECLARATION

I, (print Full Legal Name) _____ (Registration #) _____ , declare I am a registrant of the College in good standing. I understand that I must comply with the *Health Professions Act*, the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation, and College Bylaws. I must meet the requirements of each jurisdiction in which I wish to practice. I understand that my registration with the College authorizes me to use my registration title and display my certificate only **within the province of British Columbia, Canada.** I will ensure my registration number and certificate are used only by myself.

Pursuant to s.90 of the College Bylaws which states that all registrants and their employees must be insured against liability for negligence in an amount of at least $1,000,000 per occurrence, I declare that I have professional liability insurance in place to practice in the province of British Columbia, Canada and will continue renewing my policy on an annual basis whether I am registered with the College as a practicing registrant or a non-practicing registrant.

Name of Insurance Company/Underwriter	Policy Number of **Professional Liability Insurance**
Policy Period (MM/DD/YYYY) From: To:	Coverage per occurrence
Signature of Applicant	Date