

PERSONAL INFORMATION

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

REGISTRANT'S DECLARATION

I, _____ (Registrant's Full Legal Name) _____ (Registrant's #) am registered with the College as a Full registrant (R.Ac. / R.TCM.H. / R.TCM.P. / Dr.TCM.) or a Non-Practising registrant. By signing this application form, I request the College to cancel my registration immediately and I declare that I will not practice anywhere in British Columbia, Canada within the scope of practice as defined in Section 4 of the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation (Health Professions Act BC).

I will follow the [Practice Standard - Clinical Record Keeping](#) to take reasonable steps to give appropriate notification of the practice closure to each patient for whom I have primarily responsibility. I will assist the transfer of patient care to another provider.

After my practice closure, (please select one):

- I keep the patient records in my possession securely at the following location:

Patient(s) can contact me to arrange to receive a copy of their records (possibly with a fee) by the following methods:

In Writing: Address at above _____

Or write to the following address:

Telephone: _____

Email: _____

I will notify the College when any of the above contact information has changed. It is my professional responsibility to keep the files for at least a specific period (10 years since last record entry or in the case of minors, 10 years from the time the patient would have reached the age of majority (age 19 years in BC)) .

I transfer my patient records to the following custodian:

Name of person / company: _____

Address: _____

Telephone: _____

Email: _____

The person / company is aware of the legal requirements of the College to keep the files for at least a specific period (10 years since last record entry or in the case of minors, 10 years from the time the patient would have reached the age of majority (age 19 years in BC)) and agrees to do so in a secured and confidential manner.

Signature of custodian: _____

I will notify the College if and when the patient records are moved or transferred to another location or custodian.

Signature of Applicant (MUST match signature in official IDs):

Date:

- Please ensure fully complete and sign this form before submitting to CTCMA.
- Keep a copy of this request form for your file. NO document will be returned to you.
- Registrants may submit this request form to CTCMA by email in PDF form to CTCMA at registration@ctcma.bc.ca
- Registration fee is non-refundable.

