



College of Hearing Aid Practitioners of Alberta
APPLICATION FOR REGISTRATION
REGISTERED/HEARING AID PRACTITIONER
INITIAL APPLICATION FEE (NON-CANADIAN CREDENTIALS)

Supply of all information is required. Errors and omissions will delay registration. PLEASE PRINT

APPLICANTS IDENTIFICATION

TITLE Mr. Mrs. Ms Dr	SURNAME	USUAL FIRST NAME	INITIALS
MAIDEN NAME (if applicable)	Date of Birth	Email address	RESIDENCE PHONE AND AREA CODE
Address (Street/RR/POBox)			
CITY/TOWN	PROVINCE	POSTAL CODE	

HISTORY

In the past three years, I have worked as a Hearing Aid Practitioner for _____ hours.
 I have obtained credit for _____ CEU hours. (Please provide proof of CEU hours earned)

OFFICE CURRENTLY WORKING FROM

Office Name:		
Address		
CITY/TOWN	PROVINCE	POSTAL CODE
Business Phone Number (area code)	Business Fax Number (area Code)	email address (if applicable)

EDUCATION

Name of Institute Attended For Training	Date of Graduation (Month/Year)
Address (Street/RR/PO Box)	
(City/Town)	Province Postal Code
Other Educational Qualifications (Degrees, Diplomas etc)	

BOARD CERTIFICATION

I am current with the National Board for Certification in Hearing Instrument Sciences. Yes No
 Exam Date: _____ BC-HIS Number _____

EMPLOYMENT Including experience in your area of practice. List most recent employer first.

If additional space is required, attach a separate sheet.

Employer (Company Name) Address Postal Code	Contact Name & Phone Number	From (month/year)	To (month/year)
1			

2			
3			

DISCIPLINARY ACTION

Complete this section if you have ever been disciplined by any body responsible for the regulation of this or any other health profession.

Name and address of the organization _____

Reason for Discipline _____

Nature of Discipline _____

REFERENCES (Compulsory section) Provide evidence of good character and reputation

PLEASE ATTACH TWO (2) WRITTEN REFERENCES

STATEMENT

Have you ever been convicted of a criminal offence? Yes No
 Please provide details if yes.

CERTIFICATION

My signature below certifies that all information in this application is correct and complete to the best of my knowledge and belief and that I understand that intentionally false information could result in refusal of my membership. I also authorize the employers, schools or persons named in this application to provide information regarding my employment, education, character and qualifications.

_____ (date)

_____ (signature)

Amount Enclosed

\$375.00

Please make cheque payable to:

College of Hearing Aid Practitioners of Alberta

Please send CHAPA correspondence to:

Home address or Office address

Please Return to:
 Registrar CHAPA
 Ste. # 114
 2, 3012 17 Ave. S.E.
 CALGARY, AB T2A 0P9

Date Received	Office Use Only Payment Enclosed	Entries Complete						
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