College of Hearing Aid Practitioners of Alberta

APPLICATION FOR REGISTRATION

Student/Intern Membership

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	Home Email Address	RESIDENCE PHONE AND AREACODE
Address (Street/RR/POBox)			
CITY/TOWN	PROVINCE	POSTAL CODE	

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 being Attended		Commencement Date of Program
Address (Street/RR/PO Box)		Completion Date of Program
(City/Town)	Province	Postal Code
Other Educational Qualifications (Degrees, Diplomas etc)		

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 and position held	Contact Name & Phone Number	From (month/year)	To (month/year)
1			
2			
3			

DISCIPLINARY ACTION

Complete this section if you are currently undergoing an unprofessional conduct process or have previously 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) Provide evidence of having good character and reputation

PLEASE ATTACH *TWO (2)* WRITTEN PROFESSIONAL REFERENCES FROM COLLEAGUES.

STATEMENT

Have you ever been convicted of a criminal offence? Yes ☐ No ☐
Please provide copy of Criminal Record check. Mandatory – must be current within 6 months.
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

$250.00

Please make cheque payable to:

College of Hearing Aid Practitioners of Alberta

Please send correspondence from CHAPA to my
☐ Home Address or ☐ Office Address

Please Return to:
CHAPA Registrar
2308 – 62 St.
Camrose, AB
T4V 5J8

Office Use Only

Date Received	Payment Enclosed	Entries Complete		
		DB	RC	FF