

Application for Student Registration or Reinstatement

IMPORTANT INSTRUCTIONS

- 1. Provide all information requested in the application:** Attach extra pages if insufficient space is provided on the forms. Please ensure any extra pages are clearly labelled with your name, the question number to which the information pertains and numbered in sequence.
- 2. Identification:** Please submit two notarized copies of identification with your application. One of them must be government-issued and include your name, date of birth, signature and photo.
- 3. Supporting documentation:** Sections where supporting documentation is required are indicated. Submit all required documentation to support your application. If any of your official documentation is in a language other than English, you must also provide a notarized translation from a translator approved by the BC College of Nurses and Midwives (BCCNM).
- 4. Criminal record check:** You must complete a criminal record check. Instructions on how to complete a Canadian criminal record check and, if applicable, an international criminal record check will be provided to you upon receipt of your application.
- 5. Cardiopulmonary Resuscitation (CPR) certification:** Students entering or currently enrolled in the 4th year of a BCCNM-recognized midwifery education program are required to submit a copy of Cardiopulmonary Resuscitation (CPR) certification that meets the requirements as set out in the Policy on Continuing Competency.

QUESTIONS

If you have questions about how to complete this form or the requirements for student midwife registration, please contact BCCNM Registration Services at 604.742.6200 or registermidwives@bccnm.ca.

Application for Student Registration or Reinstatement

PART A — Personal information

A. Identification

Last name: _____ First name: _____ Middle name: _____

Date of birth (mm/dd/yy): _____ BCCNM ID (if applicable): _____

Address (Apt/Box/#/Street): _____ City/town: _____

Province/State: _____ Country: _____ Postal code/zip code: _____

Home tel: _____ Cell: _____ Email: _____

Supporting documentation required: Please attach notarized copies of two pieces of identification, one of them must be government-issued and include your name, date of birth, signature and photo.

B. Previous Names/Alias (including name changes, maiden names, and preferred names)

Have you ever been known by any other names? Yes No If yes, please complete:

Previous name: _____ Dates used from/to (mm/dd/yy): _____

Previous name: _____ Dates used from/to (mm/dd/yy): _____

Supporting documentation required: You must submit proof of a name change (e.g. notarized copy of a marriage certificate) if any of your documentation is in a different name than the one you are using now.

C. Indigenous Status (this section is optional and can be filled out if you wish to self-identify as an Indigenous person)

Are you an Indigenous person? Yes No

If yes, which Indigenous band and/or nation do you belong to? _____

D. Authorization to study in Canada (You must be a Canadian citizen or have authorization to reside and work in Canada)

Are you a Canadian citizen? Yes No

If no, do you have the authorization to reside and study in Canada? Yes No

Supporting documentation required: If you are a Canadian citizen, please enclose a notarized copy of your birth certificate, or citizenship card, or Canadian passport. If you are not a Canadian citizen, please enclose proof of the authorization to reside and study in Canada, i.e. a notarized copy of your permanent resident status or study permit.

Applicant name: _____

PART B — Student status and education

A. Student registration/reinstatement of registration

1. I am or will be:

A student of the (university): _____ baccalaureate midwifery program recognized by BCCNM¹.

A student of the (university): _____ midwifery bridging program recognized by BCCNM.

2. I have previously been registered as a student with BCCNM: Yes No

3. I am requesting registration for the following dates: Start date (dd/mm/yy): _____ to: _____

B. Internation midwifery education program

To be filled out if you have previously completed midwifery education outside of Canada.

1. Name of program: _____ Name of school: _____
Jurisdiction/Country where recognized: _____ Length of program: _____
Graduation date (dd/mm/yy): _____ Degree/diploma/certificate granted: _____

2. Name of program: _____ Name of school: _____
Jurisdiction/Country where recognized: _____ Length of program: _____
Graduation date (dd/mm/yy): _____ Degree/diploma/certificate granted: _____

C. Nursing program

To be filled out if you have completed nursing education².

Name of program: _____ Name of school: _____
Jurisdiction/Country where recognized: _____ Length of program: _____
Graduation date (dd/mm/yy): _____ Degree/diploma/certificate granted: _____

1 BCCNM recognized midwifery programs include: Baccalaureate Midwifery Program of University of British Columbia in BC, Mount Royal University in Alberta, and Laurentian University, McMaster University and Ryerson University in Ontario. Internationally Educated Midwives Bridging Program of University of British Columbia in BC and Ryerson University in Ontario.

2 This information is requested for the purposes of maintaining the BCCNM database only and does not pertain to the registration process.

Applicant name: _____

Part C — Midwifery registration

A. Registration in other Canadian jurisdictions

Are you currently or have you ever been registered to practice midwifery in any other Canadian province or territory?:

Yes No

If yes, please list all provinces or territories where you are currently or have previously been registered:

1. Canadian province or territory where registered: _____

Date of registration (dd/mm/yy): _____ to: _____

Current class of registration: _____

2. Canadian province or territory where registered: _____

Date of registration (dd/mm/yy): _____ to: _____

Current class of registration: _____

3. Canadian province or territory where registered: _____

Date of registration (dd/mm/yy): _____ to: _____

Current class of registration: _____

B. Other professional affiliations

Have you ever been licensed/certified/registered to practice any other health care professions in British Columbia or any other jurisdictions?

Yes No

If **yes**, please list all health care regulatory bodies and professional associations where you have ever been a registrant/member:

1. Professional body: _____ Registered from/to (dd/mm/yy): _____ to: _____

Address: _____

2. Professional body: _____ Registered from/to (dd/mm/yy): _____ to: _____

Address: _____

3. Professional body: _____ Registered from/to (dd/mm/yy): _____ to: _____

Address: _____

4. Professional body: _____ Registered from/to (dd/mm/yy): _____ to: _____

Address: _____

5. Professional body: _____ Registered from/to (dd/mm/yy): _____ to: _____

Address: _____

Part D — Disclosure of past proceedings

In accordance with BCCNM bylaws, to apply for registration or reinstatement of registration you must disclose all information that relates to you and your practice of midwifery or a health profession corresponding to midwifery in another jurisdiction, or is otherwise relevant to the safe and ethical practice of midwifery, regardless of where the event took place.

Do any of the following situations apply to you?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A finding of professional misconduct, incompetence or incapacity by a regulatory authority ³ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | An investigation in progress with a regulatory authority. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A reprimand or imposition of conditions or educational requirements by a regulatory authority as a result of a complaint. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | An agreement to an undertaking made by consent with a regulatory authority. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A dismissal for cause by an employer. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A denial of registration by a regulatory authority. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A voluntary resignation of registration on the request or advice of a regulatory authority. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any verdict and recommendations of a coroner’s investigation, inquiry or inquest. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A coroner’s investigation, inquiry or inquest in progress. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A denial, suspension, restriction or modification of hospital admitting privileges or a permit to practice. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A voluntary resignation of hospital privileges on the request or advice of a hospital or health authority administration. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A professional insurance claim. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any pending civil or criminal action, notice of claim or settlement or judgement in any civil or criminal proceeding to which you are a party. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A conviction for any federal or provincial offence. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | A physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs your ability to practice midwifery. |

If you checked Yes to any of the above, list on a separate piece of paper all incidents that relate to the relevant disclosure requirement. Include the nature of complaint or incident, the date of the incident, names and addresses of individuals, institutions, agencies or professional organizations involved, the jurisdiction where the incident occurred and any findings and outcomes. Also where applicable include a comprehensive summary addressing what you learned and the ways in which any deficits in ethics, clinical practice or preparation revealed by the matters disclosed have been remedied.

Failure to disclose any information of any previous, present, or pending matter may result in your application being rejected or revocation of your certificate to practice.

³ “Regulatory authority” means a regulatory college, professional association or governmental body that regulates a profession.

Applicant name: _____

Part F — Authorization

- Yes No I hereby authorise British Columbia College of Nurses and Midwives (BCCNM) to make such inquiries about me or the services I have provided as it considers appropriate in connection with this application for registration or reinstatement of registration made by me.
- Yes No I authorise any midwifery program(s) that I attended or any regulatory college for midwifery in a province where I have been registered, any hospital or health authority where I have held privileges, any of my clients, employers, associates or any other person or organisation which BCCNM may approach as applicable related to my education or professional practice to release information about me or the health care services I have provided.
- Yes No I further authorise BCCNM to disclose information about me or the services I have provided to other regulatory authorities, hospitals and other institutions to which I may apply for registration or appointment.
- Yes No I understand that several agencies in BC will also require information about me after I am registered. I therefore further authorise BCCNM to disclose my personal information, usually limited to my date of birth and gender, to those agencies. These agencies include but are not limited to relevant departments dealing with province-wide perinatal programs at Children's and Women's Health Centre, C.H. Wills Newborn Screening Laboratory, LifeLabs, Health Insurance BC, Ministry of Finance and Corporate Relations (Risk Management), Ministry of Health (Blood & Lab Services), Ministry of Health (Provider and Location Registry), Pharmacare, St. Paul's Laboratory and the Vital Statistics Agency.
- Yes No I understand that any information provided by me or any other person or organisation in this application may be used by BCCNM to assess my eligibility for registration at any stage of the application/registration process.
- Yes No I further understand that any false or misleading statement or representation made by me in this application may disqualify me from registration or may be cause for revocation of any registration which is granted to me.

Part G — Declaration

I, (full name) _____ of (address) _____

_____ do solemnly declare that (please check all the boxes below to confirm your declaration):

- I am the person making application for registration with British Columbia College of Nurses and Midwives.
- I have read and understood the application to which this declaration is attached.
- I am a person of good character.
- I, having read the Health Professions Act, Midwifery Regulation, the BCCNM bylaws in force, standards of practice and standards of professional ethics, will comply with the Health Professions Act, Midwifery Regulation, the BCCNM bylaws, standards of practice and standards of practice and standards of professional ethics if granted registration.
- I hereby declare that the information contained in the application to which this declaration is attached is true and complete to the best of my knowledge and belief.

Signature: _____ Date (mm/dd/yy): _____