COLLEGE OF HEARING AID PRACTITIONERS OF ALBERTA
APPLICATION FOR REGISTRATION
ASSOCIATE MEMBERSHIP

Supply of all information is requested. 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	BUSINESS PHONE AND AREA CODE	RESIDENCE PHONE AND AREA CODE
Address (Street/RR/POBox)			email address
CITY/TOWN	PROVINCE	POSTAL CODE	

I: ☐ have been a regulated member and wish to maintain contact with the College
Or
☐ am dispensing hearing aids outside of Alberta and wish to affiliate with the College.

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_____

_____

STATEMENT

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

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			

Amount Enclosed
$ 250.00

Please make cheque payable to:
College of Hearing Aid Practitioners of Alberta

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

Office Use Only

Date Received	Payment Enclosed	Entries Complete
		DB / RC / FF