College of Hearing Aid Practitioners of Alberta
APPLICATION FOR REGISTRATION
REGISTERED/HEARING AID PRACTITIONER

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/ PO Box)			
CITY/TOWN	PROVINCE	POSTAL CODE	

HISTORY

In the past three years, I have worked as a Hearing Aid Practitioner for _____**n/a**_____ 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
$625.00

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

Please send CHAPA correspondence to:
☐ Home address ☐ Office address

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

Office Use Only

Date Received	Payment Enclosed	Entries Complete		
		DB	RC	FF