



**College of Hearing Aid Practitioners of Alberta**  
**APPLICATION FOR REGISTRATION**  
 Educational Student Membership

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

**APPLICANTS IDENTIFICATION**

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

**OFFICE CURRENTLY WORKING FROM**

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

**EDUCATION**

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

**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 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 REFERENCES FROM COLLEAGUES.**

**STATEMENT**

Have you ever been convicted of a criminal offence? Yes  No

Please provide copy of Criminal Record check.

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

**\$150.00**

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

Date Received \_\_\_\_\_ Office Use Only  
 Payment Enclosed \_\_\_\_\_

Entries Complete		
DB	RC	FE
/	/	/