Government of Bermuda
Ministry of Health and Seniors
OFFICE OF THE CHIEF MEDICAL OFFICER

Council for Allied Health Professions

Application for Initial and Renewal of Registration as an Allied Health Professional

Instructions for Completing this Form

This form is to be completed by all Allied Health Professionals who are applying for initial and the renewal of full registration with the Council. In order to practice, Allied Health Professionals must be registered in accordance with the Allied Health Professions Act, 1973.

The information collected in this form will be used to determine eligibility for retention on the Register of Allied Health Professionals.

Please print all information clearly in blue or black ink. Complete every section of this application and submit the **original** application along with all required supporting documentation to the Office of the Chief Medical Officer (see bottom of this page for contact details).

If more space is needed to fully answer questions attach additional sheets with typed responses.

Section A: Registration Application Details

TYPE OF REGISTRATION APPLICATION		
Please indicate which Application Type you are submitting:	☐ Initial Registration ☐ Renewal of Registration	
Please indicate your Profession:	☐ Addictions Counsellor ☐ Audiologist ☐ Chiropodist/Podiatrist ☐ Diagnostic Imaging Technologist ☐ Dietitian ☐ Emergency Medical Technician (Basic) ☐ Emergency Medical Technician (Advanced)	☐ Medical Laboratory Technician ☐ Occupational Therapist ☐ Paramedic ☐ Physiotherapist ☐ Speech Language Pathologist ☐ Other (please specify):_____ _____

Section B: Personal Identification and Contact Information

I. APPLICANT DETAILS			
CAHP Registration #:	_____ -_____	(This applies to persons who have been previously registered with the CAHP only. Your CAHP Registration # (*e.g. PHYSIO-###*) can be found on your last issued registration certificate. If you cannot locate it please leave this field blank.)	
Full Name:			
First Name	*Middle Name(s)*	*Last Name*	
Previous Name (s): (if applicable)			
Date of Birth:		**Gender** (please check ☑):	☐ Male ☐ Female
DD/MMM/YYYY		**Nationality:**	
Immigration Status:	☐ Bermudian ☐ Spouse of Bermudian ☐ Non-Bermudian ☐ Permanent Resident Certificate Holder		
Work Permit Info:	Work Permit #: _____ Work Permit Start Date: _____ Work Permit End Date: _____		

25 Church Street, Hamilton, HM 12, Bermuda
P.O. Box HM 1195, Hamilton HM EX, Bermuda
Phone: (441) 278-4900 • Fax: (441) 292-2629 • E-mail: OfficeofCMO@gov.bm

II. RESIDENTIAL CONTACT DETAILS

*Your **residential contact details** provided below will be kept in confidence. This information is collected strictly for the purpose of registration communications.*

Physical Home Address:	
House Name:	
House/Apartment/Unit # *Street Address Line 1*	
Address Line 2 (if applicable)	
City/ Parish *State/Province/Region* *Postal / ZIP Code* *Country*	

Home Telephone:		**Personal Cell Phone:**	
Personal Email Address:			

III. PROFESSIONAL CONTACT DETAILS

*Please note the **professional contact details** provided below may be shared with other Ministry of Health regulatory entities including, but not limited to, the Bermuda Hospitals Board, the Bermuda Health Council, and Ageing and Disability Services.*

Current Position:	
Current Employer & Physical Business Address:	
Company Name, In Care Of (c/o), or To the Attention of (ATTN:)(if applicable)	
Unit, Suite, Floor # *Street Address Line 1*	
Address Line 2 (if applicable)	
City/ Parish *State/Province/Region* *Postal / ZIP Code*	
Country	

Business Telephone:		**Business Fax:**	
Business Email Address:			

IV. PREFERRED CORRESPONDENCE DETAILS

Please indicate your preference for receiving general mail correspondence from us.

Preferred Mailing Address:	☐ Home (as above) ☐ Business (as above) ☐ Other (please specify below)
Address Line 1	
Address Line 2	

Address Line 3

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Section C: Training and Professional Information

I. QUALIFICATIONS TO PRACTICE			
List Professional Degrees, Diplomas, Specializations, or Other Qualifications (list only additional qualifications since initial registration if previously registered with the CAHP).Provide original certificates or notarized copies of certificates.			
Name of Qualification/Certification	**Name of Certifying Body**	**Country of Issuance**	**Date Granted**

Section D: Screening Questions

*Answer **ALL** of the following questions by placing a check (☑) in the appropriate box. If you answer "YES" to questions 2 - 7 provide complete details on a **separate** **sheet of paper** and **submit with this form.***

1.	Have you ever been registered with Bermuda Allied Health Professions Council before?	YES ☐	NO ☐
2.	Are you licensed/registered to practice in any other jurisdiction in addition to the current jurisdiction in which you work? If yes, list each one.	YES ☐	NO ☐
3.	Have you ever withdrawn an application for registration, had an application denied or refused, or agreed not to reapply for registration in another country?	YES ☐	NO ☐
4.	Has any disciplinary action been taken against you by any licensing authority?	YES ☐	NO ☐
5.	Have you had privileges denied, revoked or restricted in a hospital or other health care facility?	YES ☐	NO ☐
6.	Have you been convicted, found guilty, or pleaded guilty or non-contestant to any offence?	YES ☐	NO ☐
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs?	YES ☐	NO ☐

Section E: Continuing Education

Registered Allied Health Professionals must complete a minimum of 24 hours of Continuing Education within the two year initial registration or renewal period. You must complete and submit the **Continuing Education Reporting Form** to show the educational courses taken.

Have you complied with the CEU requirements outlined above?	YES ☐	NO ☐
I have completed the Continuing Education Reporting Form *(attached).*	YES ☐	NO ☐

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Section F: Attestation Statement

Please note your agreement with the following:

*By my signature, I attest that the information I submit in this application and in any required accompanying or subsequent documentation is true and accurate to the best of my knowledge. Additionally, I understand that persons who apply for registration or renewal of registration as an Allied Health Professional, or persons who have been registered by the Council for Allied Health Professionals (**CAHP**), are subject to their Professional Code of Conduct & Ethics, and Standards of Practice. I attest I am informed of the requirements of Continuing Professional Development specified by the Statutory Board and the Council.*

*I understand the Council for Allied Health Professions reserves the right to not accept or delay approval of this application. I also understand that I may be subject to audit at any time and that the **CAHP** reserves the right to take action for failure to comply with audit procedures.*

*In order to maintain my registration, I understand that from time to time the **CAHP** may amend its requirements, policies and procedures, including changes to initial registration, registration renewal, Code of Conduct & Ethics, and/or Standards of Practice.*

*During my renewal cycle, I agree to notify the **CAHP** in writing immediately if I fail to comply with Professional Code of Conduct & Ethics, and/or Standards of Practice.*

*I also agree to notify the **CAHP** in writing of any address or name change(s) within thirty (30) days after the change becomes effective. If requested to do so, the **CAHP** may verify my registration status.*

I attest that I have completed all registration renewal requirements.

_____

Signature of Applicant

_____ _____

Print Name *Date*

Initial Registration Application Fee: BD$165.00 (US$165.00)

Registration Renewal Application Fee: BD$110.00 (US$110.00)

Late Registration Renewal Fee: BD$50.00 (US$50.00) Required In addition to the renewal application fee received after the renewal deadline.

Do not send cash in mail. Please make your check or bank draft payable to the **Accountant General.**

Applications should be submitted at least four (4) to six (6) weeks in advance of the applicant's intended arrival in Bermuda and employment commencement.

BY MAIL:

Ministry of Health and Seniors Headquarters
Office of the Chief Medical Officer
c/o Council for Allied Health Professions
P.O. Box HM 1195
Hamilton HM EX
Bermuda

Updated: OCT 2016

IN PERSON:

Ministry of Health and Seniors Headquarters
Office of the Chief Medical Officer
c/o Council for Allied Health Professions
Continental Building – Ground Floor
25 Church Street
Hamilton HM 12
Bermuda

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Section G: Consent to Release Information for Credentials Verification

My signature below indicates my consent to the Council for Allied Health Professions (the Council) and the Office of the Chief Medical Officer (Office of the CMO), to make enquiries relating to and for the purpose of information verification relevant to my ability to practice. Verification requests may include information relevant to confirmation of my identity, educational credentials, practice history, and criminal background.

I hereby authorize the release of information to the Council and/or the Office of the CMO, relevant to my ability to practice as a health professional by professional and character referees, training and credential verification agencies, academic and employment institutions and registration/licensure regulatory authorities located in Bermuda and other countries.

A photocopy, facsimile or emailed version of this consent form sent directly from the Council or the Office of the CMO shall be valid as the original and shall be valid for two (2) years from the date signed below. I acknowledge and agree to verification information and supplemental information to be forwarded directly to:

Ministry of Health and Seniors Headquarters
Office of the Chief Medical Officer
c/o Council for Allied Health Professions
P.O. Box HM 1195
Hamilton HM EX
Bermuda

_____
Signature of Applicant

_____ _____
Print Name *Date*

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Section H: Checklist

The following checklist is provided to assist you with ensuring you have submitted the necessary documentation to apply for registration. Application submission requirements for **Initial Registration** are listed below as items **A – Q and T** and submission requirements for **Renewal of Registration** are listed below as items **A - E and R - T**. All application submission requirements must be in English.

Item	Documentation	Check ☑ if Submitted
A.	**Application Form**	☐
B.	**Registration Application Fee** (*as per Government Fees Regulations*)	☐
C.	**Late Fee** (*for registration renewals, if application is received after **December 31st, 2016***)	☐
D.	**Attestation Statement** (signed and dated)	☐
E.	**Consent to Release Information** (signed and dated)	☐
F.	**Proof of Bermudian Status / Residency** (Bermudian Passport Stamp and Information Page; Permanent Residency Certificate / Spousal Letter) – *in lieu of these item see **Item F***.	☐
G.	**Official job offer letter from Bermuda employer** (not applicable to Bermudians and spouses of Bermudians)	☐
H.	**Letter of reference from two previous employers/supervisors** on official letterhead (most current and discipline specific)	☐
I.	**Statement of Experience / C.V.** (education and employment with dates)	☐
J.	**One passport sized photograph** (write your name on the back of photograph)	☐
K.	**Letter of Good Standing** (on official letterhead from the jurisdiction that you have been registered in for the past two years)	☐
L.	**Diplomas and Postgraduate Certificate(s) or Letter of Proof of Qualification** (Graduation) from relevant learning institution in English (in original form or a notarised copy)	☐
M.	**Birth Certificate of Internationally Recognised Passport** (in original form or a notarised copy)	☐
N.	**Marriage Certificate** (where applicable**, in original form or a notarised copy**)	☐
O.	**Professional Association Membership Card or Certificate** (if applicable, in original form or a notarised copy)	☐
P.	**Proof of current licensure/state registration in current jurisdiction of registration** (in cases when this does not exist an official letter is required from the designated authority in that jurisdiction) (in original form or a notarised copy)	☐
Q.	**Proof of competency to practice in jurisdiction** in which you were trained i.e. national certification, exam certificates (college/university transcripts, letter from college/university, where applicable) (in original form or a notarised copy)	☐
R.	Completed **CEU Reporting Form** and verifying documents of all CEU's obtained	☐
S.	For persons who have not registered in Bermuda for more than two years, but have been practicing in another jurisdiction, include an official **Letter of Good Standing** from the authorized body in that jurisdiction.	☐
T.	**Proof of Current Certifications** (if applicable – e.g. NREMT, CPR, IV Certification, ASHA, ARRT, ARDMS, NBCOT etc.)	☐

*** N.B.:**

(A) Documents generated/created/issued outside of Bermuda are to be notarized in the relevant jurisdiction. Similarly, documents that are generated/created/issued in Bermuda to be used abroad (outside of Bermuda) are to be notarized in the relevant jurisdiction.

(B) Certification of documents is appropriate when the documents are generated/created/issued in Bermuda to be used in Bermuda.

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