Application - Continuing Education Courses

Privacy and Security
The information you provide here relates to the operations of the College of Naturopathic Physicians of British Columbia (the "College") under the *Health Professions Act* of British Columbia for the purpose of regulating the practice of naturopathic medicine in British Columbia. As a public body under the provisions of the *Freedom of Information and Protection of Privacy Act (FOIPPA)*, the College provides security and confidentiality of your personal information.

IMPORTANT: The College reviews applications in the order in which they are received. You will be notified in writing of the outcome of your application.

COURSE PROVIDER INFORMATION		
Organization Name		
Name of contact person submitting the Application		
Address		
City/Town	Prov./Terr.	Postal Code
Telephone ( )	Email Address	
Fax ( )	Website	

(*updated April 2023*)

CONTINUING EDUCATION COURSE INFORMATION		
Which continuing education course category are you applying for and how many hours in that category? *(please see continuing education course categories listed on the CNPBC website: https://cnpbc.bc.ca/for-registrants/resources/continuing-education-requirements/)*		
Name of course *(as appears on certificate)*		
Location of the course:		
Is the course offered in person or online? *(provide as much detail as possible)*		
Time allocations		
Practical / Hands-on Hours	Didactic / Theoretical Hours	Total Number of Course Hours
Course Delivery Format		
☐ **In person** *(Participants practice with one another, with instructor guidance)*		***Ratio of instructor(s) to participants:***
☐ **In person - Group** *(Participants are taught in a group, led by instructor)*		***Ratio of instructor(s) to participants:***
☐ **Lecture**		
☐ **Online Course/Webinar – Live with no provider and participant interaction**		
☐ **Online Course/Webinar – Live interactive webinar with course provider and participants**		
☐ **DVD or books, with home study guide**		
☐ **Conference** *(indicate if it's a live in-person conference or online)*		

☐ **Other** *(please specify and provide details. Attach a separate page with additional details if needed)*		
Method of Attendance Verification		
☐ **Sign-in sheet**	☐ For each day	☐ For each session
Does the Course include an Assessment?		
☐ **Quiz questions** ☐ **Scenarios (role playing)** *(For any content that is not in person, at least 5 questions for each 1.0 hour of education)*		

Please attach details/supporting documents to satisfy the following:

1. Format (e.g. course, conference or seminar, in person, live webinar, recorded video);
2. Number of hours allocated to each of didactic/theoretical and practical/hands-on training and, specifically, how many hours apply to prescriptive authority if applicable; and
3. Method of verification of attendance (e.g. sign-in sheet for day, for each session; quiz questions for sessions attended online or by video).

Confirm the following supporting documentation is enclosed:

- ☐ Content overview: detailed course outline and/or agenda (**required**), and any additional materials (if available); and
- ☐ Sample certificate. Please include: name of provider; name of course, conference or seminar; name of participant; total number of hours attended; date of successful completion; and name of course instructor(s); and
- ☐ Copy of the course examination.

PLEASE SUBMIT ALL DOCUMENTATION IN PDF FORM AND WHERE POSSIBLE, AS ONE PDF DOCUMENT.

INSTRUCTOR INFORMATION *(attach completed copies of this page for each instructor, along with supporting documentation)*
Name of instructor:
Qualifications *(enclose curriculum vitae)*
Professional registration *(include licence number and full name of regulatory body)*

Confirm the following supporting documentation is enclosed:

- ☐ Curriculum vitae

Previously Approved Continuing Education Courses

List any courses offered by the organization that have previously obtained College approval, and the date (or approximate date) when the approval was issued.

APPLICANT ATTESTATION (required):

I, _____,
Name of Course Provider Representative

on behalf of_____, declare that:
Course Provider/organisation offering the course

All course instructors have the appropriate credentials for providing this education, including being licensed and/or certified, and having **at least 5 years of experience** performing the procedures and/or treatments, in the aspect of practice in which they are educating attendees.	☐ Yes ☐ No
If the course **includes demonstration or practice on live patients** (including course participants), all instructors for the course have completed a course in at least one of the following: Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or Naturopathic Advanced Life Support (NALS) within the past two years.	☐ Yes ☐ No ☐ N/A
Attendees of the course who have satisfied the competency criteria will receive a certificate of course completion, a sample copy of which is included in this application.	☐ Yes ☐ No
I consent to all legitimate and reasonable uses of the information contained within this application.	☐ Yes ☐ No
If the course includes demonstration or practice on live patients (including course participants), the course provider maintains professional liability insurance with a limit of liability not less than **$3,000,000 per occurrence** insuring against liability arising from an error, omission, or negligent act of the course provider, its instructors, and course participants during the course.	☐ Yes ☐ No ☐ N/A
Following approval from the Quality Assurance Committee, if the course has any substantial changes, you agree you will provide the College with an updated version of the course outline (syllabus) and examination.(N/A for courses offered one time only)	☐ Yes ☐ No ☐ N/A
I certify that the information contained in this application is true, complete, and accurate to the best of my knowledge. Additionally, I will notify the College: **1) of any future changes to the information contained in this application; and** **2) if I wish the course to be approved in future years.**	☐ Yes ☐ No

_____ _____ _____
Signature *Print Name* *Date Applied (yyyy/mm/dd)*

INFORMATION FOR SUBMITTING THIS FORM:

Sign and return form to the College of Naturopathic Physicians of British Columbia.

By mail: 840-605 Robson Street, Vancouver BC V6B 5J3
By fax: (604) 688-8476
By email: office@cnpbc.bc.ca

If you have any questions regarding this process, please contact the College at office@cnpbc.bc.ca or (604) 688-8236.

(*updated April 2023*)