BRITISH COLUMBIA | Ministry of Health

COPR Canadian Organization of Paramedic Regulators — OCRP Organisation Canadienne des Régulateurs Paramédicaux

COPR
Labour Mobility

For the purposes of this form:

Registration is in reference to the status of an individual as Registered (or equivalent), such that he/she has successfully completed a Canadian paramedic Regulator's entry to practice examination, and may be certified, subject to meeting the requirements of that regulatory authority.

Certification is in reference to the status of an individual as Certified (or equivalent), such that he/she holds a license, practice permit, or equivalent, issued by a Canadian paramedic Regulator that attests to the individual being authorized to practice.

Section A - Applicant Section

This section of the form is to be completed by the Applicant. This form must be completed by **every** jurisdiction in which the requestor is Registered or has been Registered.

Last name	First and middle name
Former/previous name(s)	Address (including country)
Other certifying bodies under which registration or certification is or has been issued (check all that apply) ☐ BC ☐ AB ☐ SK ☐ MB ☐ ON ☐ QC ☐ NB ☐ NS ☐ PE ☐ NL Other (please list)	
Email	Telephone
☐ I certify that the information on this form is true, correct and complete to the best of my knowledge. ☐ I authorize the collection, use and disclosure any information regarding my paramedic practice for the purpose of the verifying my status as a paramedic. I acknowledge that I have been notified about the verification process, including that information about me may be collected, used and disclosed, the purposes for which the information collected may be collected, used and disclosed, the fact that third parties may have access to that information, the fact that such information may be transferred outside of province of practice to other jurisdictions that may have different laws protecting personal information or data, and the process by which I may access the data collected about me for the purpose of correction or deletion of erroneous data. By submitting my information and signing below, I knowingly and voluntarily consent to the collection, use, disclosure and verification of information regarding my status, practice and certification as a paramedic, including but not limited to education, qualifications and employment history, and for those organizations to collect, use, disclose and verify such information. I understand and acknowledge that the information collected is required to verify and confirm my practice and good standing as a paramedic with any paramedic regulatory authority under which I currently practice, for the purposes of seeking employment opportunities in another jurisdiction.	
Signature	Date

Section B - Regulator Section

This section of the form is to be completed by the Regulator. Incomplete forms will be returned to the Applicant. This form must be completed by **every** jurisdiction in which the requester is Registered or has been Registered.

<table>
<tr><td colspan="2">Regulator</td><td colspan="2">Name of Applicant</td></tr>
<tr><td rowspan="2">Practice Level

☐ EMR
☐ PCP
☐ ACP
☐ CCP</td><td colspan="2">Registration Number</td><td rowspan="2">Registration obtained by

☐ Examination
☐ Previous Registration
☐ Labour Mobility
☐ Other, specify:</td></tr>
<tr><td colspan="2">Registration Date</td></tr>
<tr><td colspan="4">Is this Applicant currently Certified (if certification is temporary or provisional, please provide details in Additional Comments)?

☐ Yes; Certification Expiration Date:
☐ No; if No:
what was the last Certification Expiration Date:
was this Applicant a student in the previous year? ☐ Yes ☐ No</td></tr>
<tr><td colspan="4">Has the Applicant’s Registration or Certification been denied, revoked, restricted, suspended, or under review at any time?
☐ Yes (please provide details, including reinstatement status/date or conditions, if applicable, in Additional Comments)
☐ No</td></tr>
<tr><td colspan="4">Additional Comments</td></tr>
<tr><td colspan="2">Contact Name</td><td colspan="2">Contact Title</td></tr>
<tr><td colspan="4">Contact email</td></tr>
<tr><td colspan="4">Contact telephone</td></tr>
<tr><td colspan="2">Signature</td><td colspan="2">Date</td></tr>
</table>