



BC Association of Clinical Counsellors
 204 – 780 Tolmie Avenue, Victoria, BC V8X 3W4
 TEL. (250) 595-4448 Fax (250) 595-2926 Toll Free in Canada 1-800-909-6303
 hoffice@bc-counsellors.org www.bc-counsellors.org

APPLICATION FOR REGISTERED MEMBERSHIP

Please complete **all sections** of this form. Incomplete forms will be returned.

PART 1. PERSONAL

Full Legal Name: _____

(As it will appear on the Membership Certificate)

Maiden/Previous Name(s): _____

Preferred Name: _____ (As it will appear on correspondence, e.g. Tom for Thomas)

Date of Birth: (DD/MM/YYYY) _____ / _____ / _____

Mailing Address _____

City _____ Province: _____ Postal Code _____

Email: _____ BCACC uses email to communicate the status of application files

YES NO I consent to BCACC sending email to the email address I have provided for the above purpose. I understand that I may opt out of receiving emails at any time.

Telephone Numbers: Home: _____ Cell: _____ Office: _____

(Please notify BCACC Head Office immediately of changes to the above information).

PART 2. EDUCATION AND TRAINING

- List all **degrees convocated** and **dates granted**.
Sealed Official transcripts are required documentation for all education listed.

Institution	Degree	Date Granted

- Are you or have you ever been a member of any regulatory organizations? (List each organization.) Have each organization forward a Letter of Good Standing to BCACC.

- 3. Do you have an outstanding investigation, citation or disciplinary proceeding with another regulatory body?
 YES NO
- 4. Have you ever had an application to a professional counselling association (including BCACC) rejected?
 YES NO
- 5. Have you ever had a professional diploma, certificate or license suspended or revoked?
 YES NO

(* Please attach details for any yes answers to Questions 3, 4 or 5.)

- 6. List evidence of training in core counselling courses.

The onus is on the applicant to provide proof to the Registration Committee that he/she has the supervision and/or training in the areas indicated.

COUNSELLING BASE

CATEGORY	LIST COURSE NAME AND NUMBER FOR EACH CATEGORY All applicants must complete this section of the form; do not direct the Registration Committee to see transcripts.	Specify Level	
		Undergrad <input type="checkbox"/>	Graduate <input type="checkbox"/>
Normal Development and Abnormal Psychology		<input type="checkbox"/>	<input type="checkbox"/>
Counselling & Personality Theories		<input type="checkbox"/>	<input type="checkbox"/>
Group Therapy Theory and Practice	(Course work in the theory and practice of group therapy.)	<input type="checkbox"/>	<input type="checkbox"/>
Family Therapy Theory and Practice	(Course work in the theory and practice of family therapy.)	<input type="checkbox"/>	<input type="checkbox"/>
Research Design	(May include qualitative and/or quantitative research.)	<input type="checkbox"/>	<input type="checkbox"/>
Ethics	(If Ethics was covered within the context of other courses, please attach supporting documentation.)	<input type="checkbox"/>	<input type="checkbox"/>

PART 3: REFERENCES

List the names, addresses, and professional qualifications of at least two counselling professionals who will serve as your references. One of the references **must** have supervised your clinical work; the other can be a colleague. **B.C.A.C.C. requires a minimum of 100 hours of supervision. This must be documented by the supervisor on a Clinical Reference Form.**

1. Name _____
 Address _____
 City _____ Province _____ Postal Code _____
 Telephone _____ Professional qualifications _____
2. Name _____
 Address _____
 City _____ Province _____ Postal Code _____
 Telephone _____ Professional qualifications _____

(Complete and sign Section A of both Reference forms and then deliver to the persons listed above.)

PART 4: APPLICATION FEE (non-refundable) \$200.00 (\$190.48+\$9.52 GST).

Payment Method: MasterCard Visa Cheque Visa Debit

Card Number _____ Expiry Date(mm/yy) ____/____ CVV(3digit code on back of card) _____

Cardholder Signature (required for credit card payment) _____

PART 5: CERTIFICATION

I certify that the statements made by me in this application are complete to the best of my knowledge and belief. In the event of any complaint or complaints arising which suggest unethical behavior on my part prior to or during the process of application for registration, I authorize the B.C. Association of Clinical Counsellors to both investigate and to consider such information as part of my eligibility for registration.

Date _____ Signature _____

IMPORTANT:

I have read and understand the Scope of Practice, *Code of Ethical Conduct, and Standards of Clinical Practice for the B.C. Association of Clinical Counsellors.

Date _____ Signature _____

Please Note: Once your application for membership has been accepted, you will be required to either provide evidence of professional liability insurance coverage or apply for professional liability insurance.