



Canadian Institute of Public Health Inspectors
Board of Certification
Examination Application Form

Form A

Salutation (Ms., Mr.)		Print your name clearly as you wish it to appear on the certificate: First Name/Last name		DOB: dd/mm/yyyy			
Pre-Examination Mailing Address (Apartment #, Number & Street):				Home Telephone with Area Code:			
City:		Province:		Postal Code:			
Email Address:				Office Telephone with Area Code:			
Post-Examination Mailing Address (Apartment #, Number & Street) (if different from above):				Cell Phone with Area Code:			
City:		Province:		Postal Code:			
I am enclosing documents for an accommodation request: (please check one): <input type="checkbox"/> Yes <input type="checkbox"/> No							
Are your reports written in English or French (Check one): <input type="checkbox"/> English <input type="checkbox"/> French			Language in which you wish to have your oral exam (Check one): <input type="checkbox"/> English <input type="checkbox"/> French				
Province in which you wish to take the examination (please list):			If you are a Canadian Forces member: Rank: Service Number:				
Practicum Agencies (Please list all):			Dates of Practicum (dd/mm/yyyy)				
1.			From:		To:		
2.			From:		To:		
Field Reports Enclosed: Please list the titles of each report in the space provided. Please submit your electronic copies of your field reports in accordance with the instructions in the BOC Candidate Information Package							
1.							
2.							
Academic Eligibility: I have successfully completed the required Canadian academic instruction at: OR Name of Institution: BOC-Accredited Program (specify the academic track): <input type="checkbox"/> Obtained education outside of Canada and successfully completed the BOC Foreign Trained Equivalency Exam on (date):							
Official Transcripts (If repeating there is no need to resubmit): <input type="checkbox"/> Official Transcripts Enclosed <input type="checkbox"/> Official Transcripts to Come Directly from Above Listed Institution							
Is this your first exam (please check one): <input type="checkbox"/> Yes (proceed to Current CIPHI Student Membership) <input type="checkbox"/> No (proceed to next question)							
Where and when was last exam taken: Location: Month: Year:							
If you are repeating, what portion of the exam are you repeating (Check one or both): Number of Written Reports 1 <input type="checkbox"/> 2 If you were required to do an additional practicum, how many weeks? (Submit Form C): _____ weeks				Oral <input type="checkbox"/> Written Report(s) Office Use Only: Verified by CIPHI _____ Try			
I hereby acknowledge that if I submit an incomplete application, there will be an additional fee of \$100 + tax _____ Candidate Initials							
Current CIPHI Student Membership Yes <input type="checkbox"/> No (Please go to ciph.ca to sign up for membership. Current membership is required to sit the exam)							
Candidate Signature:					Date: (dd/mm/yyyy):		
OFFICE USE ONLY	Fee Paid: <input type="checkbox"/> \$850* <input type="checkbox"/> \$425* <input type="checkbox"/> \$100** *plus tax **tax inclusive	Payment Method: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Money Order <input type="checkbox"/> Certified Cheque <input type="checkbox"/> Amex	Received Forms: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	Transcript Received Date:	C.F. Cross Ref.	E-Reports Date Saved:	Practicum Pass Check <input type="checkbox"/>