PART A: INFORMATION FOR BOTH APPLICANTS AND HEALTH CARE PRACTITIONERS

This Health Care Practitioner Information Form (**"HCPI Form"**) is to be used by a person seeking a licence, registration, approval, determination, decision, or order from BC Financial Services Authority (**"BCFSA"**) pursuant to its statutory powers of decision. An Applicant who is adversely affected by a rule or requirement administered by BCFSA due to a limitation which results from or is associated with a protected characteristic under section 14 of the Human Rights Code, RSBC 1996, c. 210 (a "Protected Characteristic") may ask BCFSA for an accommodation of that limitation by submitting an Accommodation Request Form ("AR Form"), and any required supporting documentation. A person submitting an AR Form is referred to as an "Applicant" in this HCPI Form.

When an AR Form identifies **"Disability"** as the Protected Characteristic giving rise to the limitation(s) for which an accommodation is being sought, the Applicant is required to authorize the Applicant's health care practitioner to complete a HCPI Form. **Note: A practitioner who prepares and signs an HCPI Form must hold a licence in good standing issued by a professional regulator which has been established by and is governed under a statute and must be either be actively involved in the treatment of the Applicant's Disability or have conducted a fully sufficient examination of the Applicant for the purpose of this request ("Practitioner")**.

The purposes of the HCPI Form include confirming the existence of a Disability and describing the limitations which are, in the Applicant's case, associated with that Disability. It is impossible for BCFSA to assess a request for accommodation arising from a Disability without first obtaining sufficient satisfactory information to allow BCFSA to understand what limitations the Applicant has that require accommodation.

The nature, degree, and anticipated duration of the limitations reported by a Practitioner may cause BCFSA to request further and more detailed reports about an Applicant's limitations including, if necessary, information about the Applicant's diagnosis, treatment, and prognosis to ensure BCFSA is effectively discharging an established obligation to accommodate an Applicant while also discharging its mandate to protect the public interest.

An AR Form, including any associated HCPI Form, will be considered by BCFSA under BCFSA's Accommodation Statement.

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Vancouver, B.C. V6C 2T8
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BCFSA

PART B: INFORMATION FOR APPLICANTS

Please provide this HCPI Form to your Practitioner.

Please sign this HCPI Form where indicated below. Your signature will authorize your Practitioner to provide BCFSA with the requested information.

The Practitioner completing the HCPI Form should return the Form with any required supporting documentation to you. You will then submit this form to BCFSA by attaching it to your electronic AR Form.

PART C: TO BE COMPLETED BY THE APPLICANT

Name:	Licence or Registration Number (if applicable):

I hereby authorize the Practitioner named below both to confirm that I have a condition which is generally recognized and accepted within the Practitioner's discipline as a Disability and to describe the limitations which are, in my case, associated with my Disability, including the likely duration of each identified limitation, the availability of an effective treatment regime for my Disability and, if a treatment regime has been recommended, to confirm my compliance with that treatment regime.

I understand that I am being asked by BCFSA to provide and am providing this authorization as a result of and in connection with my request for accommodation of limitations which are associated with my Disability.

Signature:	Date:

BCFSA

PART D: INFORMATION FOR PRACTITIONERS

The Applicant is in the process of applying to BCFSA for accommodation of limitations associated with a Disability. In order to address the AR Form, which the Applicant will be submitting to BCFSA, BCFSA requires supporting documentation from a Practitioner. In this regard, please see the note in bold type above.

The information you provide to BCFSA through the completion of this HCPI Form will play an essential role is BCFSA's ability to determine what accommodation, if any, is appropriate for the Applicant.

Please be sure the Applicant has signed the authorization set out above. In addition, if you think you need or wish to obtain a separate authorization in a form used by your office, please do so. Once you are satisfied you have the necessary authorization to complete this HCPI Form, please answer the questions below. If you need to use additional pages to answer the questions, please indicate that you are doing so in the body of this HCPI Form and then designate the additional pages by reference to the number of the question you are answering.

PART E: TO BE COMPLETED BY THE PRACTITIONER

Professional Information

Name:	Profession:
Name of Regulatory Body:	Licence Number:
Office/Organization:	
Mailing Address:	

Daytime Phone:	Can detailed messages be left? ☐ Yes ☐ No	Email Address:

Professional Qualifications

Please set out your professional qualifications including information about your area(s) of practice and any specialties.

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PART E: TO BE COMPLETED BY THE PRACTITIONER

Confirmation of Protected Characteristic and Associated Limitations

In this section, please confirm that the Applicant has a Disability.

1. How long has the Applicant been in your care? _____

2. If the Applicant has not been in your care and you are examining the Applicant for the purposes of assessment in relation to this request, have you conducted a fully sufficient examination of the Applicant for the purposes of this opinion, and when did you do so? _____

3. Has the Applicant been diagnosed with a health condition that results in a Disability? ☐ Yes ☐ No

4. If you answered "yes" to question 3, above:

   (a) When was the Applicant first diagnosed with this condition? _____

   (b) Did you diagnose this condition? ☐ Yes ☐ No

   (c) If you did not diagnose this condition, did you confirm this condition? ☐ Yes ☐ No ☐ Not Applicable

   (d) Please describe the limitations which are, in the Applicant's case, associated with the Applicant's Disability. BCFSA will use this information to determine whether the Applicant will, as a result of the identified limitations, be adversely impacted by a rule or requirement administered by BCFSA and, if so, what accommodation may be made available for the Applicant.

BCFSA

PART E: TO BE COMPLETED BY THE PRACTITIONER

Suggested Accommodation(s)

While it is the BCFSA's responsibility in law to identify available accommodation based on the information which has been provided to BCFSA about the limitation(s) which are associated with a Disability, the BCFSA encourages you to suggest any accommodation you think might be helpful to your patient/client. BCFSA will consider any suggestions you make carefully and thoroughly.

Practitioner's Confirmation and Signature

I confirm that the information I have provided is accurate to the best of my knowledge and expertise and is within my scope of practice.

Signature:	Date:

Once completed, please return this HCPI Form and any additional pages or documents to the Applicant, for submission to BCFSA.