GOVERNMENT OF BERMUDA
Ministry of Health

Bermuda Psychologists Council

Application for Re-Registration as a Psychologist

INSTRUCTIONS FOR COMPLETING THIS FORM

In accordance with Section 12 of the Psychological Practitioners Act 2018 (the Act), in addition to meeting the qualifications, experience and conduct specified in the Act, a person is entitled to be re-registered as a psychologist if they:

1. have malpractice insurance;
2. provide evidence of having provided at least 100 hours of psychological services per year in two of the preceding three years;
3. have completed the prescribed amount of continuing education hours; and
4. pay the re-registration fee prescribed under the Government Fees Regulations 1976.

Please complete all sections of the application and print clearly in **BLOCK CAPITALS** using a black or blue pen only. Place an **X** in all applicable boxes.

The current re-registration fee can be found at: http://www.gov.bm/content/register-psychologist. Please make a cheque payable to the **ACCOUNTANT GENERAL** and attach it to your application. Cash is only acceptable if delivered by hand.

When completing the form, it is important that you refer to the Bermuda Psychologists Council's (the Council) Continuing Professional Development Programme Guidelines and Code of Conduct.

This application will not be considered unless it is complete, and all supporting documentation has been provided.

The information used in this form will be kept confidential and will only be used for the purposes of re-registration.

Please post this form with the required documents to:

Ministry of Home Affairs
Department of Registry General
Government Administration Building
30 Parliament Street, Hamilton HM 12
Bermuda

SECTION A: PERSONAL IDENTIFICATION AND CONTACT INFORMATION

I. APPLICANT DETAILS					
Full name:	*First Name*	*Middle name(s)*		*Last Name*	
Previous name(s) *(if applicable)*:					
Date of Birth:	*DD / MM / YYYY*	**Gender:**	☐ Male ☐ Female	**Nationality:**	
Immigration Status:	☐ Bermudian ☐ Spouse of Bermudian ☐ Non-Bermudian ☐ PRC Holder ☐ Work Permit Holder				
Registration Certificate No.:		**Expiration Date:**	*DD / MM / YYYY*	**Initial Date of Registration:**	*DD / MM / YYYY*

II. RESIDENTIAL CONTACT DETAILS

Home Address:	*Address Line 1*		
Address Line 2 (if applicable)			
City/Parish	*State/Province/Region*	*Postal/Zip Code*	*Country*

Mailing Address *(if applicable)*:	*Address Line 1*		
Address Line 2 (if applicable)			
City/Parish	*State/Province/Region*	*Postal/Zip Code*	*Country*

Home Phone:		**Cell Phone:**	
Personal Email Address:			
1. Would you like to join the Bermuda Psychologists Association?			☐ Yes ☐ No

III. PROFESSIONAL CONTACT DETAILS

Professional Status:	☐ Self-Employed/Private Practice ☐ Employer ☐ Both *(please provide 2nd employer/business information)*		
Business/Employer Name:		**Position:**	
Business/Employer Address:	*Address Line 1*		
Address Line 2 (if applicable)			
City/Parish	*State/Province/Region*	*Postal/Zip Code*	*Country*
Business/Employer Phone:		**Business/Employer Email Address:**	
2nd Business/Employer Name:		**Position:**	
Business/Employer Address:	*Address Line 1*		
Address Line 2 (if applicable)			
City/Parish	*State/Province/Region*	*Postal/Zip Code*	*Country*
Business/Employer Phone:		**Business/Employer Email Address:**	

SECTION B: INDEMNITY INSURANCE

I. INDEMNITY INSURANCE DECLARATION			
1. Do you currently have appropriate professional indemnity insurance in place for practicing as a psychologist? If *“**YES**”*, please provide details below and photocopy proofs of indemnity insurance.			☐ Yes ☐ No
Insurance Company	**Policy No.**	**Policy Effective Date** *DD/MM/YYYY*	**Policy Expiration Date** *DD/MM/YYYY*

SECTION C: SCREENING

I. PROFESSIONAL CONDUCT QUESTIONS	
*Answer ALL of the following questions by placing a check (☑) in the appropriate box. If you answer “**YES**” to any of the questions below, please provide complete details on a separate sheet of paper.*	
1. Have you ever had a registration or license to practice as a Psychologist cancelled or suspended in any jurisdiction?	☐ Yes ☐ No
2. Have you ever withdrawn an application for registration, had an application denied, cancelled or suspended, or agreed not to reapply for registration in any jurisdiction?	☐ Yes ☐ No
3. Have you ever had a registration or license with any professional body in any jurisdiction cancelled or suspended?	☐ Yes ☐ No
4. Has any disciplinary action been taken against you by any registration/ licensing authority in any jurisdiction?	☐ Yes ☐ No
5. Have you ever had privileges denied, revoked or restricted in any hospital or other health care facility in any jurisdiction?	☐ Yes ☐ No
6. Have you been, or are you currently, the subject of conduct, performance or health proceedings against you in any jurisdiction	☐ Yes ☐ No
7. Have you been convicted, found guilty or pleaded guilty or no-contest to any offence in any jurisdiction?	☐ Yes ☐ No
8. Do you have an impairment that detrimentally affects, or is likely to detrimentally affect, your capacity to practice the profession?	☐ Yes ☐ No

SECTION D: CONTINUING PROFESSIONAL DEVELOPMENT

I. DECLARATION OF CONTINUING PROFESSIONAL DEVELOPMENT			
For information on the continuing professional development requirements please refer to the Continuing Professional Development Programme (the CPD Programme).			
1. Have you completed a minimum of 60 hours of continuing professional development within three years?			☐ Yes ☐ No
2. Have you completed continuing professional development in at least two skill areas?			☐ Yes ☐ No
Total CPD Credits Declared:		**Period of CPD Declaration:**	*MM / YYYY to MM / YYYY*

II. CONTINUING PROFESSIONAL DEVELOPMENT SUMMARY

List continuing professional development credits below and refer to the CPD Programme in order to complete the skill area. Provide additional CPD credits on a separate sheet of paper, if necessary.

Activity	**Date** *DD /MM/ YYYY*	**Skill Area**	**CPD Credits**	**Verifying Documents** **OFFICIAL USE ONLY**
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
CPD Credits	**Total:**			

SECTION E: ATTESTATION STATEMENT

By my signature, I attest that the information I submit in this application and in any required accompanying or subsequent documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the revocation of my registration.

Please initial each statement of the attestation below

_____ I understand that persons who are registered by the Council are subject to the Code of Conduct (hereafter the Code) as prescribed under Section 8 of the Act.

_____ I confirm that I have read and understand the Code and that I am informed of the requirements of Continuing Professional Development specified by the Council.

_____ I agree to notify the Council in writing immediately if I fail to comply with the Act and/or Code.

_____ I understand that from time to time the Council may amend its requirements, policies and procedures concerning: initial registration, registration renewal, and the Code. Changes to such documents will be posted on the website of the Government portal and may occasionally be sent to me by email or by post. Any changes to the Act, Regulations, or Code made by the Minister shall be gazetted.

_____ I agree to notify the Council in writing of any address or name change(s) within thirty (30) days after the change becomes effective.

_____ I understand the Council reserves the right to not accept this application.

Signature of Applicant: ____________________________________

Print Name: ____________________________________ **Date:** ____________________________

SECTION F: CHECKLIST

The following checklist is provided to assist you with ensuring you have submitted the necessary documentation to apply for re-registration. ***Facsimile and emailed copies will not be accepted.***

ITEM	DOCUMENTATION	CHECK ☑
1.	**Application Form**	☐
2.	**Registration Application Fee** (Cheque payable to the ACCOUNTANT GENERAL)	☐
3.	**Marriage Certificate** (where applicable)	☐
4.	**Proof of Immigration Status**	☐
5.	**Documents that provide sufficient evidence of your continuing professional development hours** (copies accepted)	☐
6.	If you have answered "**YES**" to any questions in Section C and/or have additional details as per Section D, please sign, date and submit extra sheet(s) with the application	☐
7.	**Proof of Malpractice Insurance**	☐
8.	**Attestation Statement** (signed and dated)	☐