Bermuda Health Council

Certificate of Professional Education Form

Section I: Applicant Information

Instructions:

- Complete Section I. In item 3, enter your name exactly as it appears on your Application for Licensure. Be sure to sign and date item 8.
- Send the entire form to the institution(s) you attended and ask the registrar to complete Section II and forward both pages of the form directly to the Bermuda Health Council at the address at the end of this form. Be sure to include any fee required by the institution.

Note: This form will not be accepted if submitted by the applicant.

1. Full name (as it appears on your application for licensure) and date of birth

Last	First	Middle

Date of Birth (mm/dd/yy)

2. Mailing Address (you must notify the Bermuda Health Council promptly of any address or name changes)

Line 1	Line 2

City/Parish	State/Province Region	Country

3. Full name as it appears on your degree/diploma

Last	First	Middle

4. School attended

Name	State/Province/Region	Country

5. Degree/Diploma Information	
Name of qualification	Date Awarded (mm/dd/yy)

Applicant Authorization	
I request and give my permission to the school listed in item 5 above to complete Section II of this form and mail it to the Bermuda Health Council at the address at the end of this form, and to release any other information requested by the regulatory authority in connection with my application for licensure.	
Applicant's Signature	Date of Authorization (mm/dd/yy)

Section II: Registrar Certification of Education

Instructions:

- Please complete Section II below and return all pages (Section I and Section II) of this form directly to the Bermuda Health Council at the addresses at the end of this form. This form will not be accepted if returned by the applicant. An electronic copy of the completed form must be sent via email.
- Note: Non-registered or non-accredited programs must attach a transcript listing all courses taken by the applicant at the school and grades the applicant received.

1. Name of applicant (see Section I, Item 3)		
Last	First	Middle

2. Education Dates (mm/dd/yy)	
Commencement	Completion
Withdrawl (if any)	

3. Degree/Diploma Information

Name of qualification	Length of programme (years and months)	Date Awarded (mm/dd/yy)

Registrar Certification	
I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.	
Registrar's Signature	Date of Certification (mm/dd/yy)

Name:		Registrar's seal
Title Position:		
Institution:		
Address:		
Telephone:		
Email address:		

Completed forms must be returned to **Bermuda Health Council** via email (preferred) **or** via post to the following:

Email:

hpadmin@gov.bm
Subject line: COPE Form for {name of health professional}.

Post:

P.O. Box HM 3381
Hamilton, HM PX
Bermuda