Occupational Therapist Participation Agreement

Firm Details

NAME OF FIRM	FIRM VENDOR NUMBER	
EMAIL ADDRESS	PHONE NUMBER	
ADDRESS		
CITY	PROVINCE	POSTAL CODE

Occupational Therapist Details

NAME OF OCCUPATIONAL THERAPIST	COLLEGE REGISTRATION NUMBER
PRIMARY SERVICING CITY NAME	PRIMARY SERVICING CITY POSTAL CODE
SECONDARY SERVICING CITY NAME (if applicable)	SECONDARY SERVICING CITY POSTAL CODE
LANGUAGES SPOKEN (if other than English)	

Add to Hospital Discharge Program (HDP) Sub-Roster ☐ Yes ☐ No

If yes, please indicate if you have the requisite knowledge, skills and resources to accept service requests in the following areas (select any/all that apply):

- ☐ Moderate to severe traumatic brain injury;
- ☐ Spinal cord injury;
- ☐ Complex mental health (including, but not limited to, concurrent diagnoses of schizophrenia, dementia, bipolar, borderline personality disorder, substance abuse/addictions); and/or
- ☐ Pediatrics.

Add to Functional Capacity Evaluation (FCE) Sub-Roster ☐ Yes ☐ No

By indicating yes, you are declaring that you have 5 years of experience conducting FCE's utilizing a standardized system or hold a CWCE certification under a professional body.

Please refer to the most current COTBC Essential Competencies and COTBC Practice Resource on Guided Reflection prior to making the above selection(s).

I confirm that I have read and understood the Occupational Therapy (OT) Program Guide and ICBC Health Care Services Terms and that, in consideration of the benefits to be afforded to me, I agree to be bound by the terms and conditions of the OT Program Guide and ICBC Health Care Services Terms.

I understand, acknowledge, and agree that ICBC will be entitled to amend the OT Program Guide or terminate my right to participate, in each case as provided in the OT Program Guide and ICBC Health Care Services Terms.

Dated this _____ day of _____ , _____ .
DAY MONTH YEAR

_____ _____
OCCUPTIONAL THERAPIST SIGNATURE WITNESS SIGNATURE

_____ _____
OCCUPTIONAL THERAPIST NAME (please print) WITNESS NAME (please print)

Please print, sign, scan and email agreements to BIProviderApp@icbc.com

This Agreement will not be effective, and the occupational therapist will not have any rights under the Agreement, until such time as ICBC receives an originally executed copy of this Agreement.