



Head Office

825-B Laval Crescent
Kamloops, BC Canada
V2C 5P2

Canada West P: (778) 957-6407

Canada East P: (647) 250-7646

OHS REGISTRY PROVIDER PARTNERSHIP

AUTHORIZED TRAINING PROVIDER APPLICATION

ORGANIZATION INFORMATION

Organization Name:

Mailing Address:

City:

Province:

Postal Code:

Phone:

Website:

OWNER / PRESIDENT INFORMATION

Name Last:

First:

Position:

Office Phone:

Cell Phone:

Email:

PROGRAM COORDINATOR CONTACT

Name Last:

First:

Position:

Office Phone:

Cell Phone:

Email:

Same as Program Coordinator

ACCOUNTING CONTACT

Name Last:

First:

Position:

Office Phone:

Cell Phone:

Email:

Same as Program Coordinator

PRODUCT ORDERING CONTACT

Name Last:

First:

Position:

Office Phone:

Cell Phone:

Email:



Head Office

825-B Laval Crescent
Kamloops, BC Canada
V2C 5P2

Canada West P: (778) 957-6407

Canada East P: (647) 250-7646

ORGANIZATION BUSINESS BACKGROUND

PLEASE DESCRIBE YOUR ORGANIZATION'S EXPERIENCE IN TRAINING ADULT LEARNERS.

--

PLEASE PROVIDE A LIST OF COURSES YOUR ORGANIZATION CURRENTLY OFFERS

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

PLEASE LIST THE NUMBER OF INSTRUCTORS YOUR ORGANIZATION CURRENTLY EMPLOYS FULL / PART TIME

Instructors:

PLEASE LIST LOCATIONS YOUR ORGANIZATION WILL OFFER TRAINING

1.	
2.	
3.	
4.	
5.	
6.	



Head Office

825-B Laval Crescent
Kamloops, BC Canada
V2C 5P2

Canada West P: (778) 957-6407

Canada East P: (647) 250-7646

I CERTIFY THAT:

- All information provided by me in this application is true and complete to the best of my knowledge; and I have withheld nothing that, if disclosed, would alter the integrity of this application; and
- I have read the Authorized Training Provider Handbook, and I understand the requirements for my organization to achieve and maintain “good standing” status as an OHS Registry Authorized Training Provider, and
- If approved as an Authorized Training Provider, I will comply with OHS Registry requirements.

Dated:

Organization Name:

Applicant Name:

Title:

Authorized Signatory: