Health Professions Review Board
PO Box 9429 Stn Prov Govt, Victoria BC V8W 9V1
Tel: (250) 953–4956 Toll free: (888) 953–4986
Website: www.bchprb.ca Email: hprbinfo@gov.bc.ca

FORM 4
REPRESENTATIVE AUTHORIZATION

Review Board File No. _____

Between _____ (Applicant or Complainant)

And: _____ (College)

And: _____ (Registrant, if applicable)

I, _____, authorize _____
(Your Name) (Representative's Name)
to be my representative in regard to this review. My representative is authorized to receive and disclose all information relating to the review, including my personal information. I understand that the Review Board and other parties will not contact me directly and will contact only my representative.

My representative's British Columbia postal address or email address will be my address for delivery, and I understand that I am deemed to have received anything sent there.

Name _____

Address _____

Phone number _____

Email address _____

An representative who stops representing a person must immediately (1) notify the Review Board in writing stating the client has been notified; and (2) deliver a copy of the notice to all other parties.

If I decide to change representatives or act on my own behalf, I must write to the Review Board and all other parties telling them so and give a current British Columbia postal address.

If submitting this form by email:

☐ I, _____, understand that checking this box constitutes a legal signature.

If submitting this form by facsimile or Canada post, sign and date here

Signature	Date