Notice of Intent (NOI) – Recognized Programs

This form is to be used in situations where an educational institution with a recognized BC HCA program is proposing an update to HCA program delivery. The NOI confirms that an educational institution is proposing to offer the Health Care Assistant (HCA) Program in alignment with the *HCA Program Provincial Curriculum (2023)* and *HCA Program Recognition Guide (2024)*.

Please indicate the reason for form completion:

- ☐ Reporting a substantive program change[1]
- ☐ Offering a one-time funded program[2]
- ☐ Adding or moving to a new location[3]
- ☐ Adding a new program variation (e.g., HCA ESL[4])
- ☐ Adding combined delivery[5]
- ☐ Other:

1. Name of Educational Institution:

2. Program Contact Person: (e.g. Department Head)

   Name: Title:

   Telephone: Email:

3. Title of Program:

4. Anticipated Program Start Date: End Date:

5. Maximum Number of Students:

6. Submission Details: Provide full description. If a one-time funded program, list the funder and their contact information:

Important Note: To support health human resource planning, HCA education funding and training oversight at the provincial level, the Registry may copy one or more of the following agencies on one-time funded program approvals: Private Training Institutions Regulatory Unit, Ministry of Post Secondary Education and Future Skills Training, Work BC/Community Workforce Response Grant Program, any other funding contacts indicated by the program.

[1] Also submit updated program materials. See Glossary of Key Terms (Section XXVI) for definition of substantive change.
[2] If not being offered at a *recognized BC HCA program location*, also submit Form B: New Program Location
[3] Also submit *Form B: New Program Location*
[4] Also submit *Form C1: HCA ESL Program Variation*
[5] Also submit *Form C2: Combined Delivery*

7. Signature(s) by an Administrator or equivalent at the educational institution (i.e. Dean or Owner/President) and the subject matter expert (SME) retained for program development and implementation (for HCA ESL and combined delivery program development).

On behalf of the above-named educational institution, I confirm the accuracy of information provided on the NOI:

Administrator Name:		Title:	
Administrator Signature:		Date:	
SME Name:		Title:	
SME Signature:		Date:	

RETURN COMPLETED FORM AND ATTACHMENTS TO THE BC CARE AIDE & COMMUNITY HEALTH WORKER REGISTRY**. COMPLETE AND EMAIL COPY TO:** Education@cachwr.bc.ca