Context & Considerations

This submission provides clause-by-clause comments on the proposed bylaws governing Permits (Part 7) and Support Programs (Part 12). We recognize the significant effort involved in drafting this material and appreciate the College's commitment to building a comprehensive regulatory framework under the Health Professions and Occupations Act (HPOA). These sections deal with sensitive and technical domains, from corporate compliance to trauma-informed supports, and we acknowledge the complexity of the task.

At the same time, these bylaw proposals carry important implications for licensees, complainants, and the broader public. Across both Parts, we observe a concentration of discretionary authority in the hands of the Registrar, Permit Committee, and Administrators, with relatively few procedural safeguards or rights of recourse. In our view, the exercise of such discretion, particularly where decisions affect practice rights, permit eligibility, or access to support, should be accompanied by fair process, defined criteria, and meaningful transparency.

Part 7 – Permits

These provisions set out the process for issuing, renewing, amending, and cancelling HPC Permits, as well as rules regarding naming, amalgamation, share transfers, and insurance. While much of the structure mirrors Division 4 of Part 3 of the Act, the bylaws introduce extensive administrative obligations. We are particularly concerned with:

- Permit cancellation, refusal, and condition imposition powers that operate without a guaranteed opportunity to be heard.
- Absence of external review or appeal mechanisms.
- Broad discretion over name approvals and share ownership changes, without defined criteria.
- Strict consequences (e.g., cessation of practice) triggered by administrative non-compliance.

These risks are compounded for smaller or interprofessional clinics, where administrative capacity is limited. We suggest that proportionality and clarity be embedded throughout.

Part 12 – Support Programs

Part 12 operationalizes the College's new responsibilities under sections 277–298 of the HPOA to provide information, support services, and support worker access. We support the creation of this infrastructure and the intent to enhance patient safety and accountability. However, the draft framework introduces restrictive eligibility windows, financial caps, and several termination provisions that could limit access for those most affected by harm. Specific concerns include:

- Narrow eligibility cutoffs that exclude individuals based on timing or procedural outcome of a complaint.
- Discretion to deny, suspend, or revoke support on grounds like "misrepresentation" without procedural protections.
- Lack of recourse for adverse decisions.
- No integration of cultural safety, trauma-informed care, or Indigenous-led standards in the governance of support.

While these provisions aim to offer consistency and prevent misuse, they may inadvertently exclude people navigating complex or delayed regulatory processes. As with previous submissions, we offer these comments in the spirit of collaborative improvement, recognizing the need to balance administrative integrity with fairness, accessibility, and the foundational principles of the HPOA. We appreciate the opportunity to contribute to this process and support the College in building a regulatory system that is both robust and responsive.

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7.0 Permits

7.1 Registrar authorized to Act

Comments:

- Clarify whether "authorized to act" refers to a delegation of statutory authority under HPOA s. 43 or merely recognizes existing Registrar powers. If the clause intends to grant the Registrar specific powers (e.g., issuing permit refusals, initiating compliance reviews), that scope should be clearly enumerated here or cross-referenced to the relevant Part of the Act or these bylaws.
- Consider whether this bylaw is necessary at all. If section 43 of the HPOA already applies by default, this clause may be redundant unless it's meant to assert or limit discretion in a particular way.
- If this is intended to delegate a particular decision-making authority (e.g., under a specific division), that should be expressly stated. Otherwise, the clause risks being too vague to be enforceable or meaningful.

7.2 Health Profession Corporation Permit Application

Comments:

- Recommend adding a requirement for the College to publish the form and content requirements of applications. This supports transparency and protects applicants from discretionary or inconsistent information requests. Also consider adding a timeline (e.g., 60 days) within which the Registrar must issue a decision to prevent indefinite administrative delay.
- The bylaw grants the Registrar broad discretion to determine the form and manner of the application. It should specify that the application requirements must be published or otherwise made publicly accessible to ensure transparency and consistency.
- The scope of information the Registrar may request is not defined. The bylaw should clarify whether additional documentation or declarations may be required as part of the application process.
- No timelines are set for application processing or decision-making. The absence of defined timeframes may lead to delays and lack of accountability. Consider including a service standard or reference to an administrative procedure.

7.3-7.5 General Requirements

Section 7.3 – HPC Permit Application Requirements
Comments:

- The Registrar's authority to approve the form of the solicitor's certificate and acknowledgements is broad and undefined. The bylaw should require that approved forms be published or made available upon request to ensure transparency and consistency. The requirement under 7.3(j) to pay "any amount… owed to the College prior to the In-Force Date" may expose applicants to retroactive liability and should be legally clarified. Consider adding a transitional note or cross-reference to validate the enforceability of pre-HPOA debts. Also: replace "owned" with "owed" to correct the typographical error noted in the memorandum.
- The acknowledgement language imposed on licensee shareholders is extensive and appropriate but may be overly legalistic. Consider whether a plain language summary is necessary to ensure informed consent, especially for new or international licensees.
- Section 7.3(j) refers to outstanding amounts owed to the College by a Permit Applicant or a Licensee described in section 59(1)(a) or (b) of the Act. The phrasing is unclear and may benefit from restating this requirement more directly, such as applying it to any eligible licensee or company that legally or beneficially owns voting shares in the corporation as described in the Act.
- Section 7.3(k) allows the Registrar or Permit Committee to request any other information reasonably required. This open-ended clause should be narrowed by referencing a standard of relevance or necessity, or by requiring reasons for additional information requests to prevent arbitrary or inconsistent application.

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- There is no indication of how compliance with professional liability insurance under 7.3(h) will be verified or enforced after issuance. Consider referencing an administrative check or follow-up mechanism in coordination with 7.4.

Section 7.4 – Insurance Timing Conditions
Comments:

- The restriction on providing health services prior to insurance activation is necessary but should specify whether a violation constitutes grounds for suspension, citation, or permit revocation to clarify consequences.
- The requirement for "immediate" written confirmation is vague. Consider setting a specific time frame (e.g., within 5 business days) to support enforceability.

Section 7.5 – Permit Issuance Conditions
Comments:

- This section raises practical concerns for multi-licensee corporations. If two or more licensees are voting shareholders and one subsequently becomes non-practising for reasons such as health or family leave, they would become ineligible to hold voting shares unless an exemption is granted under 7.5(b). This would force a share sale, triggering financial and tax consequences. Consideration should be given to allowing licensees who move to non-practising or other classes to retain shares, provided they remain licensed, to avoid unnecessary hardship and corporate disruption.
- The bylaw appropriately limits ownership to specific licensee classes but does not define how the Permit Committee exercises its discretion under 7.5(b). If discretion is intended to accommodate situations like temporary status changes or inter-professional ownership, criteria or guiding principles should be established.
- The reference to "satisfying the requirements under Division 4 of Part 3 of the Act" is broad. Consider cross-referencing the specific sections relevant to corporate structure and permit eligibility to assist applicants and prevent misinterpretation.
- Section 7.5(b) appears to allow discretion for licensees in "other classes," but definitions are not provided. It is assumed this is limited to licensees of the College. In the context of cross-disciplinary practices, this raises the question of whether it is appropriate or desirable to restrict voting shareholders to regulated health professionals overseen by this specific College. Clarification is needed on whether inter-professional ownership is permitted or excluded under this provision.

7.6-7.12 Health Profession Corporations Names

Comments:

- The name approval process grants significant discretionary authority to both the Registrar and the Permit Committee without defined criteria beyond general compliance. Consider adding guidance or reference to objective standards such as professional conduct, regulatory integrity, or public interest to reduce the risk of arbitrary or inconsistent refusals.
- The "likely to confuse or mislead the public" standard under 7.6(b) mirrors the BC Business Corporations Act, which already prohibits approval of names that resemble those of existing corporations on the provincial registry. Since that screening is conducted at the time of incorporation and across a broader pool of entities, requiring a second, profession-specific review by the College may be redundant. It is unclear whether the confusion standard under 7.6(b) applies only within the health professions context or more broadly. Greater clarity is needed to define the scope and purpose of the College's role in name approval.
- The bylaw does not address whether a Health Profession Corporation may operate under a "doing business as" (DBA) or trade name. Section 7.6 may functionally prohibit this, given its emphasis on name conformity and public transparency. Consider clarifying whether alternate or business names are permitted and under what conditions.

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- Bylaw 7.7 restricts use of a licensee's name to those who are voting shareholders and actively practising. This is a reasonable integrity safeguard but may require clearer mechanisms for confirming "active" status over time, especially in multi-owner corporations.
- The layered approval pathway (Registrar → optional referral to Permit Committee) provides flexibility but lacks an appeal or reconsideration process. Consider whether applicants should have recourse if a name is rejected by either the Registrar or the Committee.
- Section 7.10 gives the Permit Committee broad discretion to approve or reject an HPC Permit Application but does not require reasons to be provided in the event of a rejection. The bylaw should require the Committee to give written reasons, particularly if a proposed name is rejected, so that applicants understand the basis for the decision and what changes may be necessary for approval. This would support procedural fairness and reduce unnecessary resubmissions.
- Bylaw 7.11 provides transitional protection for legacy names, which supports continuity. However, the conditions under which that protection ends are broad. Clarify whether a routine permit renewal (with no change in structure or services) could inadvertently trigger a name re-evaluation.
- Section 7.11(b) should clarify that the Regulator cannot refuse to renew an HPC Permit under section 7.31 solely on the basis that the corporation is using a legacy name deemed compliant under 7.11. Without this clarification, legacy permit holders may face uncertainty during renewal despite having protected status.

7.13-7.14 PLP and Insurance

Comments:

- The insurance requirement in 7.13 is clearly stated but lacks reference to verification, renewal frequency, or proof mechanisms. Consider specifying how and when proof of coverage must be provided to the College (e.g., annual submission, on request, or upon material change).
- The $2,000,000 minimum coverage amount aligns with common professional standards but may not reflect sector-specific risk variation across designated health professions. Consider whether the bylaw should allow the College or Permit Committee to require higher coverage where warranted.
- The phrase "every person under their supervision or employ" in 7.13(b)(ii) is broad and may include administrative or non-clinical staff. Clarify whether the intent is to capture only those directly involved in delivering health services or advice.
- Bylaw 7.14 functions as a limited exemption but relies heavily on the assumption that all individuals involved are licensees with their own insurance. There is no mechanism for confirming or monitoring this status. The College may be exposed to regulatory gaps unless a declaration or attestation requirement is introduced.
- The exemption in 7.14 could incentivize Health Profession Corporations to structure operations narrowly to avoid carrying corporate-level insurance. While that may be acceptable, the College should consider whether this creates any unintended liability or enforcement issues.

7.15 Consequences of failing to maintain PLP

Comments:

- The requirement to cease providing health services immediately is appropriate, but the bylaw does not specify the enforcement mechanism or potential regulatory consequences for non-compliance. Consider clarifying whether failure to comply may result in suspension, citation, or revocation of the HPC Permit.
- The obligation to notify the Registrar within seven days is a minimal safeguard. Given the public protection rationale, consider whether the Health Profession Corporation should also be required to disclose this lapse to affected patients or employers where applicable.

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- There is no provision for reinstatement after coverage is restored. Consider whether the bylaw should include a reactivation process, such as providing proof of insurance and receiving confirmation from the Registrar before resuming practice.
- The bylaw does not address partial lapses in insurance coverage, such as when coverage lapses for one profession but not others within a multi-profession corporation. It is unclear whether a lapse for one licensee would require all practitioners to cease practising or whether others may continue. Clarification is needed to ensure consistent and fair application in these scenarios.

7.16-7.17 Notification of Changes

Comments:

- Section 7.16(a) appropriately requires Permit Committee approval for name changes but lacks detail on the approval criteria or timelines. Consider referencing the same standards used under the initial name approval process to ensure consistency.
- Section 7.16(d) requires written notification to the Registrar of any changes in previously provided information, including changes to ownership, shareholders, and directors. It is unclear whether this also includes changes to the addresses of directors or shareholders. Since director addresses are typically included in corporate filings, clarification is needed on whether such changes trigger a notification obligation under this provision.
- The requirement to provide a new certificate of solicitor "if requested" under 7.16(c) lacks a standard for when or why this may be required. To avoid unpredictability, this should be linked to specific types of changes (e.g., change in legal structure, ownership disputes, or amalgamation).
- Section 7.17 imposes an immediate notification obligation for any loss of eligibility but does not specify how the College will respond (e.g., temporary suspension, conditional period to rectify). Consider adding a reference to College discretion in determining the consequence of non-compliance to guide expectations and reduce procedural uncertainty.
- The cumulative effect of 7.16 and 7.17 is a strong emphasis on administrative monitoring. However, there is no indication of how the Registrar tracks or verifies ongoing compliance. Consider recommending that the College implement a regular attestation or renewal declaration process to ensure sustained accuracy of corporate records.

7.18 Amalgamation of Health Profession Corporations

Comments:

- The requirement to obtain written approval from the Permit Committee prior to amalgamation is appropriate, but the bylaw does not specify what criteria or factors the Committee will consider in granting or withholding approval. Consider whether approval should be guided by defined considerations such as compliance history, liability insurance continuity, or oversight safeguards.
- The bylaw does not clarify what happens to existing HPC Permits after amalgamation. It should specify whether the amalgamated corporation retains one of the existing permits, must apply for a new one, or may choose between multiple active permits. This is particularly important for corporations that operate under more than one permit and require certainty for continuity and compliance.
- The requirement in 7.18(b) to provide a "certificate of change of name" is inaccurate and may cause confusion. Under the *Business Corporations Act*, amalgamations result in a **Certificate of Amalgamation**, not a certificate of name change. Furthermore, the amalgamated corporation may either adopt a new name or retain the name of one of the pre-existing corporations. The bylaw should clarify that if the new entity adopts a new name, that name must be approved in accordance with Bylaws 7.6 and 7.7. If the name remains the same, no additional approval should be required.

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- Section 7.18(c) permits the Registrar to request a new certificate of solicitor but provides no guidance on when or why this would be necessary. This discretion should be tied to specific legal changes, such as alterations to share structure or governance, to promote consistent and fair application.

7.19 Restoration of Health Profession Corporation

Comments:

- Section 7.19(a) requires a licensee to obtain written approval from the Permit Committee before seeking restoration of a dissolved Health Profession Corporation. This should be clarified to mean that regulatory approval must be obtained before filing the final restoration application under the *Business Corporations Act*, but that preliminary steps such as publishing the notice of intent to restore in the BC Gazette may proceed concurrently. This would allow the restoration process to move forward efficiently, while still ensuring that the Regulator retains control over final approval.
- The bylaw does not indicate what factors the Permit Committee will consider in granting or denying approval. Without defined criteria, there is a risk of arbitrary or inconsistent decision-making. Consider referencing fitness to practise, outstanding compliance issues, or corporate structure as relevant considerations.
- Section 7.19(b) appropriately requires submission of the certificate of restoration but does not address the status of the prior HPC Permit. Clarify whether the original permit is reinstated or whether the corporation must reapply in full for a new permit.
- As with earlier provisions, the Registrar's discretion to request a new certificate of solicitor under 7.19(c) is open-ended. Aligning this requirement with material changes in ownership, structure, or governance would support predictability and limit unnecessary administrative burden.

7.20 Prohibited Activities

Comments:

- The phrase "contrary to the proper and ethical practice of a Designated Health Profession" is broad and undefined. Without reference to specific standards, codes of ethics, or College guidelines, this provision may be too vague to enforce consistently. Consider linking this prohibition to established professional conduct standards or College policies to provide clarity and legal certainty.
- The bylaw does not specify whether the restriction applies to *all* activities of the corporation or only those related to the provision of health services. This could create ambiguity around passive investments or subsidiary business operations. Clarification may be needed to delineate scope.
- There is no mention of process or consequences for breach. Consider whether a breach would result in investigation, suspension of the HPC Permit, or a requirement to divest from the prohibited activity — and whether the Permit Committee or Registrar has discretion in enforcement.
- It is unclear whether this provision applies retroactively to existing business arrangements at the time of permit issuance. Including a transitional or grandfathering clause may be necessary if enforcement is intended on a forward basis only.

7.21-7.22 Designated Licensee

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Comments:

- The role of the Designated Licensee is framed broadly as responsible for both College communication and administrative compliance, but the scope of responsibilities is not further defined. Consider whether additional detail should be provided in policy or guidance (e.g., responsibility for insurance filings, updating corporate records, responding to compliance audits).
- Requiring the Designated Licensee to be both a licensee and a voting shareholder ensures accountability but may exclude otherwise suitable individuals (e.g., senior clinicians who are not shareholders). If the intent is to tie legal authority to accountability, that should be clearly justified in governance rationale.
- There is no mention of the process for replacing a Designated Licensee or reporting changes to the College. Consider adding a notification requirement (e.g., within 14 days of a change) to ensure continuity of communication and oversight.
- The bylaw does not specify whether the College will verify the Designated Licensee's eligibility or whether any approval is required. Clarification of whether this is a registration-only or approval-based designation would support procedural clarity.
- Section 7.22 sets out the eligibility criteria for a Designated Licensee but does not require that the individual be "in good standing." In contrast, the CCHPBC's other bylaws include this as a requirement. While "good standing" may require clearer definition, it is generally understood to mean a licensee without limitations, conditions, or suspensions affecting their ability to practise. Requiring the Designated Licensee to be in good standing would support public protection and operational accountability.

7.23-7.25 Disposition of Shares

Comments:

- Section 7.23 effectively restates the statutory restriction under s. 59 of the Act but does not specify how the College will monitor or enforce compliance. Consider referencing a requirement to report all share transfers or pledges, even if to eligible persons, to ensure oversight.
- Section 7.24 introduces a layered and rigorous approval process for new voting shareholders, which may help maintain regulatory integrity but risks being overly burdensome for intra-professional transactions. The process should be proportionate to risk — consider whether exemptions or streamlining should apply for routine changes among already-approved licensees.
- The obligation to submit acknowledgements and certificates for both direct transferees and indirect holding companies creates clarity but adds complexity. The bylaw should include a mechanism for confirming when a previously submitted acknowledgement is still valid, especially for multi-tiered ownership structures.
- The solicitor's certificate in 7.24(d) is again required but the criteria for when and why remain undefined. To prevent administrative overuse, consider linking this requirement to material structural changes rather than all new shareholder admissions.
- Section 7.25 appropriately addresses potential name non-compliance due to share transfers. However, it assumes the Health Profession Corporation will self-identify the compliance issue. Consider adding a review trigger — for example, the Registrar may require name re-evaluation upon review of a proposed transfer — to ensure enforcement is proactive rather than reactive.
- Section 7.25 refers to Bylaw 7.6 in the context of requiring a name change, but this appears to be an error. Bylaw 7.6 does not itself require a name change, except through a cross-reference in 7.6(c). The intent was likely to reference Bylaw 7.7, which directly addresses name change requirements. This should be corrected to avoid misinterpretation.

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7.26-7.28 Term of Permit

Comments:

- Section 7.26 establishes a fixed annual expiry date for HPC Permits but does not specify the renewal process, timelines for submission, or consequences of late renewal. For example, applications must be submitted before March 1st and at least 14 days before expiry to avoid a late fee. Consider cross-referencing or clearly establishing the renewal protocol to prevent confusion and administrative delay.
- The phrase "unless the Permit Committee directs otherwise" grants discretionary authority to alter the expiry date without stated criteria or process. To ensure procedural fairness and predictability, consider limiting this discretion to defined circumstances (e.g., new permit issuance late in the year).
- Section 7.27 provides a transitional continuity clause for legacy permits, which is appropriate. However, the wording does not address whether such corporations must otherwise meet current HPOA and bylaw requirements (e.g., insurance, designated licensee, shareholder eligibility) prior to March 31, 2026. Consider clarifying that deemed permits are still subject to ongoing compliance.
- Section 7.28 sets a 30-day deadline for reporting the Designated Licensee but does not indicate consequences for failure to comply. If the Designated Licensee is foundational for communication and accountability under these bylaws, consider linking non-compliance to administrative action, such as suspension of deemed permit status or issuance of notice to comply.

7.29 Annual Renewal Fee

Comments:

- The due date for the renewal fee precedes the permit expiry date (March 31), but no grace period, late penalty, or consequence for non-payment is specified. Consider clarifying whether failure to pay by March 1 results in automatic lapse, late fee assessment, or administrative notice.
- The bylaw does not specify how the renewal fee is set, reviewed, or published. Consider referencing the applicable schedule (e.g., Schedule "__") to ensure transparency and enforceability.
- There is no mention of how payment must be submitted (e.g., online portal, cheque, EFT) or whether confirmation of receipt will be issued. Including these procedural details, either in the bylaw or a policy document, would support administrative clarity and reduce disputes.

7.30-7.34 Requirements for Renewal of Permit

Comments:

- Section 7.30 sets out a comprehensive list of renewal requirements but lacks clarity on how the College will assess a Health Profession Corporation's compliance with the Act, Regulations, and Bylaws. It is unclear whether compliance will be verified through random audit, attestation-only, or formal review of submitted corporate documents. Clarifying the review process would promote consistency and help prevent disputes during renewal.
- Section 7.30 references March 1 as the renewal deadline, but Section 7.26 allows the Permit Committee to establish an alternate expiry date. This bylaw should reflect that possibility and state that the renewal package must be submitted "before March 1 of each year or before such other date as may be prescribed by the Permit Committee if an alternate expiry date has been directed."
- The requirement under 7.30(c) to submit a certificate of good standing under the *Business Corporations Act* imposes an additional cost and administrative step. A more practical alternative would be to require

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confirmation that the corporation's most recent annual report has been filed. A certificate of good standing only confirms that filings are current, which could be demonstrated without requiring a separate paid request from the corporate registrar.

- Section 7.30(g) allows the Registrar or Permit Committee to request "any additional information or records." Without any qualifying standard, this grants broad discretion that could lead to inconsistent or overly burdensome requests. Consider adding a reasonableness threshold such as "reasonably required to assess eligibility for renewal," or referencing guidance materials to clarify the scope of this discretion
- Section 7.31 gives the Registrar authority to refuse renewal for non-compliance but does not require notice, reasons, or an opportunity to respond before refusal. This creates procedural fairness concerns. Consider including a minimal notice-and-response mechanism before denial.
- Sections 7.32 and 7.33 impose escalating late penalties and attestations, which support enforcement. However, the bylaw does not indicate whether the Registrar has discretion to waive fees or allow limited extensions in extenuating circumstances (e.g., administrative error, medical leave). Consider whether limited discretion should be built in for fairness.
- Section 7.34 establishes a hard cutoff for reinstatement. This provides clarity but may result in permit lapses for minor procedural delays. If reinstatement as a "new applicant" imposes materially greater burdens, consider adding a reinstatement pathway subject to Committee review where justified.

7.35 Application to Vary Permit

Comments:

- The bylaw does not define what constitutes a "variation" of an HPC Permit. Without clarification, it is unclear whether this applies to changes in services offered, shareholder structure, business location, or other operational aspects. Consider defining or listing examples of material variations that require a formal application under this section.
- The phrase "any additional information or records" in 7.35(d) grants broad discretion to the Registrar or Permit Committee. As with prior sections, this should be tied to relevance or necessity to prevent open-ended or inconsistent demands.
- No timelines are established for the College's processing or response to a variation application. Given the potential impact on business operations, consider adding a service standard or acknowledgment period to provide applicants with procedural certainty.
- There is no indication of whether variation applications are subject to approval, conditions, or denial. Consider clarifying whether the Permit Committee or Registrar may impose terms or refuse the variation and, if so, under what standard or with what recourse.

7.36 Imposition of Limits and Conditions

Comments:

- The authority to impose limits or conditions is broadly stated but lacks reference to procedural safeguards. Consider including a requirement to provide written reasons for any imposed condition, and to offer the applicant an opportunity to respond or request reconsideration, in order to meet minimum standards of procedural fairness.
- The bylaw does not distinguish between conditions imposed for administrative reasons (e.g., missing documentation) versus those related to compliance concerns or prior misconduct. Clarifying this distinction may help prevent perceived arbitrariness and support proportional application of conditions.

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- The example in 7.36(a) references compliance with section 58 of the Act (eligibility standards), but does not explain what would trigger a periodic reporting requirement. Including illustrative criteria — such as a recent change in ownership, prior lapse in liability coverage, or restoration after dissolution — would help guide consistent application.
- The general authority to require proof of corporate standing under 7.36(b) is reasonable, but it would benefit from a defined frequency or trigger (e.g., annual verification, post-amalgamation) to avoid open-ended or duplicative requests.

7.37-7.39 Notice of adverse application decision by the Permit Committee

Comments:

- Section 7.37 establishes a right to request reconsideration but does not define what constitutes an "adverse application decision." To improve clarity and prevent disputes, the bylaw should explicitly reference common examples such as refusal to issue, renew, or vary an HPC Permit.
- Unlike the CCHPBC's earlier bylaws, which required the Permit Committee to provide written reasons for an adverse decision within 30 days, this bylaw includes no obligation for timely notice or reasons. The College should be required to notify applicants of an adverse decision with reasons in writing, and ideally within a specified timeframe.
- The 30-day window for submitting a request for reconsideration is procedurally fair, but the bylaw does not state whether the College must acknowledge receipt or issue a reconsideration decision within a set period. Adding a response timeline would support transparency and administrative accountability.
- Section 7.38 provides that reconsideration hearings will be conducted in writing unless the Registrar determines that "exceptional circumstances" justify a different format. This reverses the procedural presumption in prior bylaws, which defaulted to oral hearings. Given that these decisions can materially affect a licensee's or corporation's rights and operations, the default should favour an oral hearing unless there are compelling reasons to proceed in writing. Applicants should also be entitled to request an oral hearing, with any refusal requiring written reasons.
- Section 7.39 permits cancellation of an HPC Permit by request or consent but does not require confirmation that the corporation has ceased providing health services or resolved all outstanding obligations. To avoid regulatory gaps, consider requiring a final attestation of compliance and insurance status before cancellation is finalized.
- It is unclear whether cancellation under 7.39 is immediate or subject to administrative confirmation. Consider clarifying whether the Registrar must issue a formal notice of cancellation and whether there are any post-cancellation obligations (e.g., records retention, patient referrals).

7.40-7.41 Permit Committee may act under Section 114 of the Act

Comments:

- These provisions grant the Permit Committee broad authority to act under section 114 of the HPOA, either independently of or in conjunction with a Regulatory Complaint. While this aligns with the Committee's oversight role in addressing corporate-level contraventions, the bylaws do not provide any threshold or criteria for initiating such action. This may lead to inconsistent application or procedural overlap with individual disciplinary processes.
- The absence of procedural safeguards such as notice to the corporation, disclosure of allegations, or an opportunity to respond before action is taken raises fairness concerns, particularly where action proceeds in the absence of a formal complaint. The bylaw should reference or incorporate these safeguards to ensure due process.

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- The distinction between corporate and individual accountability is not clearly articulated. If a matter involves both a Health Profession Corporation and a Licensee, the bylaws should clarify how the Permit Committee's actions will be coordinated with those of the Inquiry Committee or Discipline Tribunal to avoid duplication or contradictory outcomes.
- It is also unclear what kinds of orders, conditions, or sanctions the Permit Committee may impose under section 114. For transparency and predictability, the bylaw should cross-reference the range of available measures or set limits to ensure proportionality and prevent overreach.

7.42-7.44 Notice of proposed disciplinary action

Comments:

- Section 7.42 appropriately incorporates procedural requirements beyond the Act but does not clarify whether the Health Profession Corporation is entitled to disclosure of the evidence or allegations underpinning the proposed disciplinary action. Without this, the opportunity to request a hearing may be procedurally hollow. Consider specifying a minimum disclosure obligation.
- The provision of a hearing opportunity in 7.42(b) is important, but the bylaw does not state whether the Permit Committee is bound by the hearing outcome or retains discretion regardless. Clarifying the effect of the hearing would strengthen procedural fairness and legal clarity.
- Section 7.43(a) allows the Permit Committee to determine the hearing format but does not establish a default. To promote procedural fairness, the bylaw should state that an oral hearing is the default, unless the Health Profession Corporation requests written submissions or exceptional circumstances justify a written process. This would align with natural justice principles, particularly where the outcome may significantly affect the corporation's operations.
- The clause in 7.43(c) allowing hearings to proceed despite non-attendance or failure to submit is enforceable, but the bylaw should specify what constitutes sufficient "proof of delivery", e.g., registered mail, electronic delivery confirmation, to ensure fairness and prevent disputes.
- The 14-day notice period in Section 7.44 is procedurally minimal and may not provide sufficient time for a Health Profession Corporation to prepare for a meaningful hearing, particularly if legal or evidentiary issues are involved. The bylaw should extend the minimum notice period to at least 30 days. In addition, it should expressly allow the Permit Committee or Registrar to grant adjournments or extensions for cause, to ensure fairness and adequate opportunity to respond.

7.45-7.52 Hearing process

Comments:

- Section 7.45 appropriately sets out hearing rights, including representation and the ability to call and cross-examine witnesses. However, the framework does not specify timelines for disclosure of evidence or witness lists. Without minimum disclosure rules, procedural fairness could be compromised.
- The inclusion of culturally appropriate affirmations in 7.45(c) is positive but may require supporting policy or guidance to ensure respectful and consistent application across diverse practices and traditions.
- Section 7.46 gives the Permit Committee broad discretion to control hearing procedures, but it does not expressly require adherence to principles of natural justice. The bylaw should state that, in exercising its procedural discretion, the Committee must comply with the duty to act fairly, including providing notice, the right to be heard, and impartial decision-making. This would ensure procedural safeguards are upheld throughout the hearing process.
- Section 7.48 presumes public access to oral hearings unless otherwise directed. The bylaw should clarify under what conditions a hearing may be closed (e.g., protection of sensitive personal health information, risk of prejudice to ongoing proceedings) to balance transparency with confidentiality obligations.

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- Section 7.49 references a Tariff of Costs in Schedule "__", but that schedule has not been made available for review. Without access to the schedule, it is not possible to meaningfully assess the fairness, proportionality, or potential deterrent effect of cost awards. The consultation process should clearly indicate when the schedules will be released for public comment to ensure transparency and allow for informed feedback.
- Sections 7.51 and 7.52 mandate timely delivery of decisions with reasons, which supports procedural integrity. However, "as soon as practicable" is vague. Consider setting a presumptive timeframe (e.g., within 30 days) to ensure accountability and to support potential judicial review timelines.

7.53 Reinstatement

Comments:

- The bylaw references compliance with Bylaws 7.3 and 7.5 but does not clarify whether reinstatement is treated identically to a new application or if any prior approvals or documentation may carry over. Consider clarifying whether previously submitted materials (e.g., acknowledgements, solicitor's certificates) can be re-used if still current and unchanged.
- As in earlier provisions, the authority of the Registrar or Permit Committee to request "any additional information or records" is broad and undefined. This discretion should be tied to relevance or materiality to avoid unpredictable or excessive compliance burdens.
- There is no indication of how reinstatement applications are evaluated, nor whether the applicant has any right to a hearing or reconsideration if reinstatement is denied. Consider aligning the process with earlier provisions on refusals (e.g., Bylaw 7.37) to ensure procedural fairness and consistency.
- The bylaw does not define whether there is a time limit after permit expiration beyond which reinstatement is not permitted (e.g., must apply as a new applicant under Bylaw 7.34). Clarifying this relationship would help prevent overlapping or conflicting application pathways.

7.54 Marketing by Health Profession Corporation

Comments:

- Section 7.54(a) establishes a duty to disclose corporate status in marketing, but does not specify how or where this must be stated (e.g., website, signage, business cards, advertisements). Consider requiring that the disclosure be "prominent and clear" to ensure compliance and reduce the risk of misleading the public.
- The obligation in 7.54(b) to comply with marketing bylaws "as if it were a Licensee" creates ambiguity. A corporation cannot be a licensee under the Act, and some provisions may not logically apply (e.g., personal testimonials, clinical title use). The bylaw should specify which obligations apply, or at least clarify that only *relevant* provisions are enforceable against corporations.
- Section 7.54(b) requires Health Profession Corporations to comply with the marketing and advertising bylaws "as if it were a Licensee," but those referenced bylaws are not yet available for review. It is not possible to assess the scope, appropriateness, or applicability of this requirement without access to the specific provisions. The relevant bylaws should be released for consultation alongside this section to enable meaningful public and stakeholder feedback.
- There is no mention of how marketing compliance will be monitored or enforced. Consider referencing the Registrar's or Inquiry Committee's authority to investigate misleading or non-compliant marketing by corporations, especially where it could impact public trust.

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7.55 Information to the public

Comments:

- The bylaw authorizes public disclosure of specified information about a Health Profession Corporation but does not identify the legal basis or privacy standard under which this disclosure is made. To ensure compliance with the *Freedom of Information and Protection of Privacy Act* (FIPPA), the College should clarify that such disclosure is limited to non-personal information or otherwise authorized by law.
- The phrase "may disclose" grants broad discretion to the Registrar without setting out when or why disclosure might be withheld. If the intent is to routinely disclose this information, the bylaw should state that explicitly to provide clarity and consistency.
- Shareholder and director names are subject to disclosure, but there is no indication that these individuals will be notified in advance. While not required under corporate law, the College should consider informing applicants at the permit stage that certain information may be made public to reduce confusion or future disputes.
- The inclusion of the Designated Licensee's contact information in the list of disclosable items should be limited to business or professional contact details. The bylaw should expressly exclude personal contact information to prevent inadvertent privacy breaches.
- The authority to disclose shareholder names under section 7.55(b) is questionable. The HPOA does not expressly authorize public release of shareholder information, and under the *Business Corporations Act*, such information—particularly for non-voting shareholders—is not public. Unless the College requires shareholder consent as part of the permit application, it is unclear whether this bylaw alone provides sufficient authority for disclosure. Disclosure of non-voting shareholders should be reconsidered, especially where those individuals are not licensees and do not control the corporation.

12.0 Support Programs

12.1-12.2 Policies and Procedures

Comments:

- The delegation of authority to the Registrar to establish support program policies under 12.1 is broad and lacks requirements for transparency, consultation, or oversight. Consider adding a requirement for public posting of policies or periodic review by the College board or Permit Committee to ensure accountability.
- Section 12.2 references the matters in section 277(1) of the Act but does not summarize or contextualize them. To improve clarity and enforceability, consider incorporating a brief cross-reference or summary (e.g., fitness-to-practice, health monitoring, treatment programs), or require that any program be clearly identified as falling within the s. 277 scope.
- There is no indication of whether participation in a support program may be mandatory, voluntary, or conditional (e.g., linked to regulatory proceedings). If these programs may affect licensure or permit status, consider clarifying the relationship between participation and regulatory consequences.
- The bylaw does not specify whether affected licensees or corporations will have rights of appeal, review, or access to legal support in the context of support program decisions. Even if not included in the bylaw itself, related procedures should be developed and referenced to ensure procedural fairness.

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12.3 Support Programs

Comments:

- This section mandates the establishment of three Support Programs but provides no definitions or descriptions of scope, function, or eligibility criteria. Without clarity, it is unclear whether these programs are for licensee wellness, public education, regulatory compliance, or other purposes. Consider adding definitional cross-references or requiring detailed program descriptions in College policy.
- It is not specified whether these programs are for individuals (e.g., licensees, support workers, patients), organizations (e.g., health profession corporations), or both. This ambiguity could create confusion regarding participation obligations, funding, or access rights.
- There is no indication of how these programs will be governed, funded, or evaluated. If the programs are to have operational or financial implications for licensees or HPCs, the College should provide for transparency and consultation mechanisms (e.g., annual reporting, notice-and-comment process).
- The inclusion of a “Support Worker Program” implies regulated interaction with non-registrants or unregulated care providers. This may engage broader scopes of authority and liability that are not addressed elsewhere in the bylaws. Clarification of the legal and professional relationship between licensees and "support workers" would be prudent.

12.4-12.6 Appointment of Administrators

Comments:

- These provisions centralize appointment authority in the Registrar without requiring transparency, qualifications, or oversight. Consider adding minimum competency requirements or requiring that appointments be documented and publicly reported to support legitimacy and accountability.
- Section 12.4(b) contemplates co-administered programs with other regulatory colleges but provides no governance structure or decision-making framework for joint administration. Without inter-college agreement protocols, this could result in inconsistency, disputes, or unclear accountability.
- Section 12.6 permits the Registrar to appoint themselves as an Administrator, creating a potential conflict of interest where policy oversight, operational control, and adjudicative discretion may be concentrated in a single office. Consider requiring board ratification or a declaration of conflict process to mitigate governance risk.
- There is no mention of term limits, review processes, or removal mechanisms for Administrators. Including provisions for performance evaluation or revocation for cause would help ensure program integrity and public confidence.

12.7 Administrator may exercise power of Support Officer

Comments:

- This provision delegates the powers of a Support Officer to an Administrator but only for the purpose of determining eligibility for Information Services. However, neither “Support Officer” nor “Information Services” is defined in the bylaws, creating ambiguity around the scope of discretion being exercised. Clear definitions or a cross-reference to relevant policies would improve interpretability and enforceability.
- Concentrating eligibility decisions in the hands of the Administrator (who may also be the Registrar under 12.6) could create concerns about impartiality, particularly where access to services may affect regulatory outcomes

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or equity of access. Consider adding a right to review or appeal eligibility determinations to ensure procedural fairness.

- The bylaw does not clarify whether the exercise of Support Officer powers under this section is subject to any oversight, documentation, or transparency requirements. Establishing a standard decision-making process or requiring written reasons could support consistent and accountable administration.

12.8 Appointment of Support Officers

Comments:

- This section mandates that the Registrar designate at least one Support Officer per Support Program, including those co-administered with other regulatory colleges. However, no qualifications, selection criteria, or accountability mechanisms for Support Officers are set out. Consider requiring the establishment of eligibility criteria or a formal appointment policy to ensure transparency and public trust.
- As with previous provisions, the centralization of appointment authority in the Registrar—without oversight or reporting obligations raises governance concerns. For programs impacting registrants' access to supports or regulatory status, independent or arms-length appointment processes may be more appropriate.
- The requirement in 12.8(b) for cross-college coordination mirrors 12.4(b) but again lacks structure for shared governance or dispute resolution. Consider whether formal agreements (e.g., MOUs) or bylaw references to inter-college standards should be required for co-administered programs.
- It is not specified whether a Support Officer may serve more than one program (as is permitted for Administrators under 12.5). This distinction should be clarified to ensure sufficient capacity and avoid role conflict.

12.9-12.11 Application for Support

Comments:

- Section 12.9 places full procedural control over application content and form in the hands of the Administrator, without requiring the application criteria or process to be public. To ensure transparency and procedural fairness, consider requiring that application forms and policies established under Bylaw 12.1 be published or made readily available to potential applicants.
- The phrase "as otherwise requested by the Administrator" in 12.9(b) grants open-ended authority to demand additional information, which could create barriers to access or discourage applicants. Consider limiting requests to information that is "reasonably necessary to assess eligibility" or linking them to specific program objectives.
- Section 12.10 appropriately requires proof of authorization for third-party applications, but does not specify what forms of proof will be accepted (e.g., written consent, power of attorney, guardian designation). Without clarity, this may lead to inconsistent application or delay.
- Section 12.11 outlines the process for referring a completed Support Application to a Support Officer but uses the vague standard "as soon as reasonably practicable." To promote timely access to services and ensure accountability, the bylaw should include a clear timeline. For example, the Administrator should be required to act "within three days of receiving a completed Support Application." The bylaw should also clarify how and when applicants will be notified if their application is transferred under section 280(2) of the Act to ensure transparency and prevent confusion.
- Section 12.11 also permits the Administrator to bypass referral by directly exercising Support Officer powers under section 282(2). However, the criteria for eligibility under section 282(1) are not clearly set out or referenced. Allowing the Administrator to make determinations and act as a Support Officer introduces a

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potential conflict of roles. To preserve procedural fairness, the bylaw should require written justification for such decisions and provide the applicant with notice and an opportunity to respond or request review.

- The transfer mechanism in 12.11(b) refers to s. 280(2) of the Act but does not explain under what conditions a transfer may occur (e.g., change in jurisdiction, type of support sought). Consider outlining procedural safeguards for applicants, such as notification of transfer and retention of application timelines.

12.12-12.14 Support Officer's eligibility decision

Comments:

- Section 12.12 permits the Support Officer or Administrator to determine eligibility for Information Services using both the criteria set out in applicable policy and "any other criteria" they reasonably believe are relevant. This open-ended discretion under clause (b) raises concerns about transparency and accountability. Any criteria used to assess eligibility should be clearly set out in the policy itself, or the policy should at minimum describe the types of additional factors that may be considered and how they will be applied. Without such safeguards, applicants may face inconsistent or opaque decision-making.
- Section 12.13 authorizes the Support Officer to determine the form of Support and impose limits or conditions, but it does not specify how those decisions are to be made. To ensure transparency and accountability, the process for determining limits or conditions should be prescribed in policy. This would help ensure that decisions are consistent, proportionate, and clearly communicated to applicants.
- Section 12.14 requires delivery of written reasons for eligibility decisions, which supports procedural fairness. However, the phrase "as soon as reasonably practicable" is vague. Consider establishing a service standard (e.g., within 30 days of application) to ensure timely decision-making.
- The provision for notifying a third-party applicant (12.14(c)) only with authorization is appropriate and privacy-compliant. However, the bylaw could specify acceptable forms of authorization (e.g., signed consent form, power of attorney) to prevent confusion or delays in complex cases.
- There is no stated right to appeal or seek reconsideration of an adverse eligibility decision. Without such a mechanism, applicants may have no recourse even in cases of procedural or factual error. Consider aligning with administrative justice principles by introducing a limited right to internal review.

12.15-12.17 Reconsideration of adverse eligibility decision

Comments:

- Section 12.15 establishes a right to seek reconsideration, which fills a critical gap identified in prior provisions. However, it is limited to eligibility decisions and does not appear to extend to decisions about the *form, scope, or conditions* of Support provided. Consider clarifying whether all substantive determinations, not just binary eligibility, are reconsiderable.
- Section 12.16 implies that the same Support Officer or Administrator who made the original decision also conducts the reconsideration. This raises fairness concerns, as reconsideration ideally involves review by a different decision-maker to allow for independent internal appeal. The bylaw should clarify who decides the reconsideration and consider providing for an alternate or escalating review pathway.
- Section 12.17 sets the default for reconsideration hearings as written submissions unless "exceptional circumstances" justify another format. While this may be appropriate for lower-stakes matters such as requests for information, it may be insufficient where access to substantive support services is denied. The bylaw should describe the types of circumstances that may justify an oral hearing and consider reversing the default where

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the impact on the applicant is significant. Clear criteria would improve procedural certainty and ensure proportional fairness.

- There is no timeline for conducting or concluding the reconsideration process. As with earlier decision points, consider imposing a reasonable service standard (e.g., within 30 days of receiving the request) to prevent procedural drift and ensure predictability.
- Finally, the bylaw is silent on whether the reconsideration decision is final or subject to further review (e.g., judicial review, complaint to the College). If final, this should be stated clearly. If not, referral pathways should be indicated to support access to justice.

12.18-12.20 Administrator's Support determination

Comments:

- Sections 12.18 and 12.19 are difficult to interpret without additional context or reference to the specific provisions of the Act and applicable policies. This may limit accessibility and clarity for licensees and support applicants. These sections appear to indicate that once an applicant is found eligible, the Administrator must determine the nature and scope of the support to be provided in accordance with the Act and relevant policy. Consider revising the language to make this process clearer and more user-friendly, and ensure that any referenced policies are available to applicants to support transparency and informed participation.
- Section 12.19 refers to entitlement to a Support Worker but provides no indication of how intensity, scope, or duration of assistance will be determined. To avoid discretionary inconsistency, consider adding language that such determinations must be proportionate to need, clearly documented, and reviewable.
- Section 12.20 permits the Administrator to defer a Support determination pending reconsideration, which is logical. However, there is no obligation to notify the applicant of the deferral or provide a timeline for resolution. This could create uncertainty or perceived delay. Consider adding a requirement that deferral decisions be communicated in writing with an estimated timeframe for follow-up.
- Across these provisions, the dual authority of the Administrator as both procedural gatekeeper and implementer of Support raises concerns of role conflict and concentrated discretion. Mitigating this risk may require separating oversight and service functions or, at minimum, requiring transparency and reasons for determinations affecting access to care or regulatory standing.

12.21 Notice of Support determination

Comments:

- This provision supports procedural fairness by requiring that notice of the final support determination be provided to key parties. However, it is not immediately apparent that the overall process involves two distinct steps: determining eligibility, and then determining the scope or type of support. Stating this structure more clearly in the bylaw would make the process more accessible to applicants and licensees.
- Requiring separate determinations and notices for eligibility and for support type may introduce unnecessary administrative complexity and delay. The College should consider whether a single, integrated decision and notice could improve efficiency and reduce burden on applicants and staff.
- Clause 12.21(b), which requires the Support Officer to send notice to the Support Officer who made the eligibility decision, appears redundant unless two different individuals are involved. If that is the case, the bylaw should specify that notice is only required where the decision-maker differs. Additionally, the bylaw does not account for the possibility that an Administrator may have exercised the powers of a Support Officer under section 282(2) of the Act. That role should also be referenced for consistency.

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- The phrase "as soon as reasonably practicable" is vague and does not provide applicants with a predictable timeline. A standard timeframe (such as 10 to 15 business days) should be included to support timely service delivery.
- The bylaw should specify the required contents of the written notice. At a minimum, it should include a summary of the support granted or denied, any conditions or limits imposed, the reasons for the decision, and whether the determination is final or subject to further review. Including these elements would align with principles of natural justice and help ensure decisions are actionable.
- The ability to notify a third party under clause 12.21(c) is consistent with privacy law, but the acceptable form of applicant authorization should be standardized through policy. This would provide clarity and reduce the risk of delays or disputes over consent.

12.22-12.24 Reconsideration of Support determination

Comments:

- These sections establish a right to request reconsideration of a Support determination, which is important given the broad discretion administrators have in setting scope, limits, and conditions of support. However, the process appears overly complicated and potentially burdensome. Applicants must first be deemed eligible, then wait for a separate decision on what support will be provided, and then potentially engage in a third process to request a change to that support. The rationale for separating these decisions is not clear, and it may delay or discourage access to services.
- The term "adverse" Support determination is not defined. It is unclear whether partial approvals, conditions on support, or denial of a preferred Support Worker would qualify. Greater clarity is needed to ensure applicants understand when and how they may challenge a decision. It is also unclear whether applicants can challenge the type of support provided if a different form was requested but not granted. Without this clarity, applicants may be left uncertain about their rights.
- Section 12.23 directs the reconsideration request to the same Administrator who made the original decision. This undermines the fairness and legitimacy of the process. Best practice would be to assign reconsideration to a different individual or internal panel to ensure impartiality and promote public confidence in the process.
- Section 12.24 defaults to written submissions unless the Administrator determines there are exceptional circumstances. The bylaw does not define what qualifies as exceptional or whether an applicant can request an oral hearing. Especially where trauma or significant impacts are involved, the ability to request an alternate format should be guaranteed, and reasons for denial should be provided in writing.
- There is no timeline for how quickly a reconsideration must be decided once requested. Establishing a benchmark, such as 30 days from receipt, would support timely resolution and reduce administrative uncertainty.
- The bylaw does not indicate whether the outcome of a reconsideration is final or subject to further review, such as judicial review or internal complaint. Providing clarity on finality and next steps would support transparency and informed participation.
- As the scope and nature of available supports remain undefined, it is difficult to assess how significant these procedural rules will be in practice. Ongoing consultation and engagement will be necessary as policies are developed to ensure the support program is fair, accessible, and responsive to the needs of those it is intended to serve.

12.25 Application to change Support determination

Comments:

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- This provision allows a Recipient to request a change to their Support determination, which is essential for flexibility in dynamic or evolving circumstances (e.g., health status, professional obligations). However, the bylaw does not specify what kinds of changes may be requested — increased support, extended duration, substitution of a Support Worker, removal of conditions, etc. Clarifying the scope would assist both applicants and administrators in managing expectations.
- There is no indication of how the Administrator is required to process or respond to such a request. To ensure procedural consistency and fairness, consider requiring:
    1. That the Administrator provide written reasons for any change or refusal,
    2. That requests be assessed against defined criteria (e.g., material change in circumstances), and
    3. That decisions be made within a specified timeframe (e.g., 30 days).
- It is also unclear whether a refusal of such a change is itself subject to reconsideration or review. Aligning this pathway with earlier reconsideration provisions (e.g., Sections 12.22–12.24) would improve procedural clarity and consistency.
- Finally, the bylaw should require that applicants be informed of their right to make such a request *at the time of initial Support determination*, to ensure equitable access and reduce procedural barriers.

12.26-12.28 Appointment of Support Workers

Comments:

- Section 12.26 authorizes the Registrar to set policies governing Support Workers, including qualifications and assignment procedures. To ensure the integrity and trustworthiness of the support program, the policy should also include safeguards to prevent conflicts of interest. This should involve clear criteria for identifying potential conflicts and a defined process for reassigning Support Workers when necessary. Including these provisions would help protect applicants and reinforce accountability.
- Section 12.27 imposes a reasonableness standard on Administrators when matching Support Workers to Recipients, but the criteria ("education, training, experience…") are open to subjective interpretation. Consider requiring documentation of how the match was assessed and providing Recipients with an opportunity to request a reassignment or raise concerns without penalty.
- There is no mention of cultural safety, trauma-informed care, or alignment with a Recipient's identity, communication needs, or lived experience. Including such considerations in either this bylaw or the mandated policy would strengthen alignment with DRIPA and the *In Plain Sight* recommendations.
- Section 12.28 provides for reimbursement of Support Workers but only "in accordance with the applicable policy." To prevent disputes or inequity, the bylaw should require that this policy be made available to Support Workers and Recipients, and specify whether reimbursement includes travel, preparation, or time-based compensation.
- None of these provisions address whether Support Workers are independent contractors, College-appointed agents, or affiliated with another body — a clarification that would be important for understanding legal liability, confidentiality obligations, and scope of authority.

12.29- 12.30 Additional powers and duty to ensure compliance

Comments:

- The phrase "changes to a determination" is unclear. It should be clarified whether this means that an Administrator or Support Officer may revise a prior decision on eligibility or support provision on their own initiative, without a request from the applicant. If so, this raises procedural fairness concerns and should be

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accompanied by requirements for notice, justification, and an opportunity for the applicant to respond. Clear guidance is needed to ensure transparency and consistency in decision-making.

- This section grants wide investigatory discretion to Administrators and Support Officers, allowing them to request any "relevant" information from applicants, recipients, or Support Workers. However, the term *"relevant"* is not defined or constrained, which risks inconsistent application and potential overreach. Consider limiting this authority to information "reasonably necessary" to assess or monitor compliance with the Act, Bylaws, or applicable policy.
- There is no procedural framework for how information requests are made (e.g., in writing, with timelines, or notice of consequences for non-compliance). To protect due process and ensure cooperation, the bylaw should outline:
    1. A requirement for written notice,
    2. A reasonable deadline for response,
    3. A warning of implications for failing to comply (if any), and
    4. Reference to applicable privacy protections.
- There is no requirement that the information requested be proportionate to the purpose of the inquiry. Adding such a standard would help ensure that requests do not intrude on privacy unnecessarily or impose undue burdens, especially on vulnerable Recipients.
- This section implicitly allows for ongoing or retroactive monitoring of support recipients and workers. To ensure accountability, consider requiring that all requests and responses be documented and subject to audit or administrative review, particularly where support services intersect with regulatory risk or fitness-to-practice determinations.
- Finally, no mention is made of how this power interacts with confidentiality or privileged information (e.g., therapeutic or legal records). Clarifying boundaries — or requiring informed consent — would help avoid future rights conflicts or legal challenges.
- Section 12.30 imposes a duty on Administrators and Support Officers to ensure that Support Workers and providers of Support Services comply with applicable legal and policy requirements. However, the phrase "reasonable steps" is undefined and could lead to inconsistent enforcement. Consider requiring that oversight measures (e.g., training verification, performance tracking, complaint response protocols) be documented in policy and reviewed regularly.
- The bylaw does not specify whether non-compliance by Support Workers must be reported, escalated, or lead to suspension or reassignment. A clear consequence or corrective pathway should be established to protect recipients and ensure accountability.
- There is no mention of how recipient feedback or complaints about Support Worker conduct will be incorporated into compliance monitoring. Including a mechanism for recipient input would align with trauma-informed and patient-centered practice.
- Finally, clarify whether Support Workers are bound by the same confidentiality, privacy, and cultural safety obligations as registrants under the Act or Code of Ethics. This is critical where Support Services involve vulnerable populations or intersectional harm.

12.31-12.34 Information Services

Comments:

- Section 12.31 defines eligibility broadly, including both complainants and persons *who experienced conduct* that *may* be misconduct — even if no formal complaint is made. This inclusive framing is appropriate and trauma-informed. However, "Program Parameters" are not defined or required to be made public. Consider requiring that they be published or summarized to avoid opaque eligibility screening.

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- The scope and purpose of "Information Services" under Section 12.32 are unclear. It is not evident whether these services involve simply providing basic information about College processes or include more active assistance, such as helping someone prepare a complaint. Without more context or access to the policy referenced in Bylaw 12.1, it is difficult to assess whether the threshold in 12.32(a) is appropriate. If the intent is merely to provide general information, requiring a determination of whether someone can "meaningfully participate" may be unnecessarily complex. Consider whether the criteria in this section should be reserved for policy, where greater clarity and examples can be provided.
- Section 12.33 allows the Administrator to authorize any person to provide Information Services if they have "sufficient knowledge." There is no requirement for training, oversight, or role clarity for these individuals. To safeguard quality and accountability, consider requiring:
    1. Minimum qualifications or orientation;
    2. Confidentiality and conflict of interest declarations;
    3. A clear distinction between general information and regulatory advice.
- Section 12.34(a) gives Administrators the power to decline, suspend, or terminate services if an inquiry is deemed "frivolous, vexatious, or an abuse of process." While such discretion may be appropriate in exceptional cases, applying this threshold at the information-seeking stage raises concerns. It risks pre-emptively characterizing inquiries as illegitimate before a complaint has been made, potentially discouraging public engagement with the College's processes. The bylaw should clarify whether this threshold applies only after a pattern of behaviour is established, and consider the following safeguards:
    1. Requiring written reasons for denial or termination;
    2. Providing an opportunity for the recipient to respond or seek reconsideration;
    3. Referencing an appeal or review pathway to ensure procedural fairness.
- More broadly, the inclusion of this clause raises questions about the complexity of rules governing basic Information Services. As these services are designed to help the public understand and navigate complaint processes, a presumption in favour of access, particularly for vulnerable or equity-deserving individuals, would better reflect the College's public protection mandate.
- Section 12.34(b) affirms that receiving Information Services does not entitle individuals to information beyond what is already publicly available. This protects due process and confidentiality, but should not limit the ability of Support Officers or Administrators to help individuals access, interpret, or apply public materials in a culturally safe and accessible manner. Including this clarification in policy or guidance would enhance usability and trust.

12.35 Selecting a Service Provider for Support Services

Comments:

- This provision allows Recipients to request their preferred category of Service Provider, which is essential for patient agency and trauma-informed access. However, the discretionary phrase "accepted by the Administrator as qualified" appears in all subsections (a)–(c) without any defined criteria, transparency obligation, or appeals mechanism. This creates risk of arbitrary exclusion or inconsistent approval. Consider requiring:
    1. That acceptance criteria be published in policy under Bylaw 12.1;
    2. That reasons be provided for denial of a requested provider;
    3. That a Recipient may seek reconsideration or propose an alternate.
- The inclusion of both regulated and unregulated professionals is appropriate and culturally flexible. However, without guardrails or assurances of baseline qualifications (e.g., training in trauma-informed or culturally safe care), the provision may expose Recipients to variable or unvetted service quality. A requirement for minimum standards or policy-based vetting is advised.

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- Subsection (c)'s reference to "persons or organizations... qualified to provide trauma-informed care, or culturally-competent trauma support" is important for alignment with DRIPA and *In Plain Sight*. However, cultural safety must not be treated as interchangeable with trauma-informed practice. Consider explicitly requiring:
    1. Recognition by the relevant community (e.g., Indigenous-led validation of cultural competence);
    2. That recipients can request a provider with shared lived experience or cultural background.
- There is no indication of how funding is allocated across these options — whether all categories are equally supported, or whether some are capped or prioritized. Lack of funding transparency could deter recipients from exercising real choice. Consider requiring that funding availability and any provider-related limits be communicated at the outset of the support process.

12.36 Information to Support funding for Support Services

Comments:

- The scope of Administrator discretion is broad, including open-ended authority to request "any other information" under (f), without limits or review. This creates risk of inconsistent or excessive demands. Consider requiring that requests be proportionate and tied to published policy under Bylaw 12.1.
- The requirement for a criminal record check (12.36(b)) may deter culturally aligned or community-based providers, especially those who are unregulated. A risk-based or role-based threshold should be established to ensure proportionality.
- "Disqualifying familial relationship" (12.36(d)) is undefined. Without clarification, this may be inconsistently interpreted or applied. Criteria should be stated or referenced in policy.
- There is no obligation to inform Recipients in advance of these documentation requirements. Without upfront clarity, this could delay access or funding for services already provided.
- There is no recourse for a Service Provider or Recipient if funding is withheld or a provider is deemed "not fit." Consider adding a mechanism for reconsideration or dispute resolution.

12.37-12.41 Support Services

Comments:

- Section 12.37 limits eligibility for Support Services to individuals who have submitted a Regulatory Complaint and only if that complaint has not yet been disposed of, transferred, or dismissed. This framework may unintentionally exclude individuals who remain engaged in related proceedings, such as reconsideration requests or judicial reviews. The bylaw should clarify whether support may continue during these extended processes, particularly where the impact of the original conduct persists or the complainant remains involved in College or legal proceedings.
- Conditioning eligibility on the filing of a Regulatory Complaint under 12.37(a) may also disadvantage individuals affected by registrant conduct who are unable or unwilling to file a formal complaint due to trauma, systemic barriers, or power dynamics. This approach risks undermining access for equity-deserving groups. Consider whether Support Services could be offered temporarily to assist individuals prior to the formal filing of a complaint, with the option to extend support based on evolving needs.
- Finally re: 12.37, the categorical bar on accessing support after a complaint is "disposed of" may be overly rigid, particularly in cases where the resolution was unsatisfactory, the process was re-opened, or harm is ongoing. The bylaw could permit late or post-disposition applications in defined circumstances, such as when trauma, appeal, or barriers to access have delayed engagement with support programs.

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- Section 12.38 permits denial based on failure to provide information or "misrepresentation" without defining either term or requiring a notice process. This creates a risk of procedural unfairness. Consider requiring that denials be issued in writing with reasons and an opportunity to respond or correct the record.
- Section 12.39(d) permits the Administrator to suspend or terminate Support Services based on a Service Provider's recommendation. However, the bylaw does not indicate whether the recipient will receive notice of the recommendation, an explanation, or an opportunity to respond. The process should require that reasons be provided and that the recipient be informed in writing. If the recommendation is based on issues unrelated to eligibility or need, such as interpersonal conflict or service delivery problems, the bylaw should include a process for transferring the recipient to another Service Provider. This would promote continuity of support and help ensure that services are not interrupted for reasons outside the recipient's control.
- Section 12.40 sets a $10,000 cap and a two-year limit on funding for Support Services, but it is unclear how the funding is administered. If it is delivered on a reimbursement basis, this may create a barrier for individuals without the means to pay upfront. To ensure accessibility, the bylaw or policy should clarify whether direct payment to service providers is available.
- The two-year timeline currently begins from the date of the eligibility determination, but this may differ from when the applicant is notified or when services begin. For fairness and full access, the period should run from the date the applicant receives written notice of the Support determination.
- The bylaw requires that all three conditions under 12.40(b)(i)–(iii) be met in order for support services to continue past two years. This could result in support ending prematurely where a complaint is still subject to reconsideration or judicial review. The reference to Bylaw 12.37(b) should be broadened to account for such circumstances.
- Section 12.41 appropriately requires the Registrar to create a policy governing extensions. However, the bylaw should also provide discretion to increase the funding cap in cases where the nature, severity, or duration of harm justifies it. This would align the program more closely with trauma-informed and equity-based principles.
- To promote transparency and consistency, the funding extension policy should be made publicly available and include clear, equity-informed criteria and processes for both time extensions and funding increases.

12.42-12.46 Support Worker Program Parameters

Comments:

- Section 12.42 mirrors the restrictive eligibility structure in 12.37, excluding access to a Support Worker once a Regulatory Complaint has been disposed of, dismissed, or transferred. This may prevent individuals from receiving assistance during later or more complex stages of proceedings, including appeals or oversight complaints. Consider allowing limited eligibility extensions where procedural engagement is ongoing.
- Bylaw 12.42(b) lists specific actions or outcomes that terminate eligibility for the assistance of a Support Worker, but it does not address reconsideration requests or applications for judicial review. This creates uncertainty about whether support remains available during ongoing or reopened proceedings. The bylaw should clarify whether assistance can continue where the complainant is still actively engaged in College or legal processes and the impact of the underlying conduct remains unresolved.
- As in 12.43, denial based on failure to provide documents or "misrepresentation" lacks clear definitions, procedural safeguards, or a notice and response mechanism. Risk of discretionary or uneven application. Consider requiring written reasons and an opportunity to respond before termination or denial.
- Termination based on a Support Worker's recommendation (12.44(c)) lacks required input from the Recipient. This may be inappropriate in cases of conflict or misalignment. A notice process or requirement to seek Recipient input should be considered before action is taken.
- Bylaw 12.45 outlines when Support Worker assistance will terminate but does not clarify whether support can continue during a reconsideration or judicial review process. This gap risks disrupting care while the

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complainant remains actively engaged with the College. The bylaw should explicitly permit ongoing support during such proceedings to prevent procedural disadvantage.

- Additionally, the fixed timelines in 12.45(a) may not reflect the actual duration of harm or the regulatory process, particularly where delays, appeals, or oversight complaints arise. Consider allowing discretion to extend assistance based on ongoing need, unresolved proceedings, or trauma-informed considerations.

- The three-month termination windows following key decisions are strict and inflexible. They may not account for trauma recovery, cultural healing timelines, or access delays. Consider whether these limits should be minimums or guidelines rather than absolutes.
- Section 12.46 appropriately limits disclosure of personal information without consent, but does not clarify acceptable forms of consent or how disputes (e.g., scope of consent) will be handled. This may lead to uncertainty for Support Workers or Recipients.

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