



Initial Registration Application Form

You must submit an *Initial Registration Document Checklist* with this form.

Please refer to the *Initial Registration Application Guide* when completing this form.

Do not submit this form if you have completed an online application form by logging in to your CMTO profile.

A. Personal Information

First Name	Commonly Used Name (if applicable)	Last Name	Middle Initial
Preferred Salutation (e.g., Mr. Ms. Mrs. Miss)		Gender: M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/> _____	CMTO ID Number

B. Home Contact Information

Street Address	City/Town	Province	Postal Code
Home Phone #	Cell Phone #	Email Address	

C. Business Contact Information (if applicable)

If you have not provided the College with a business address, your home address will be deemed to be your practice location and listed on the Public Register. If you have additional practice locations, please provide all of the following information on a separate sheet of paper.

Effective Date of Employment (mm/dd/yyyy)	Business Name		
Street Address	City/Town	Province	Postal Code
Business Phone #	Business Email Address	Business Website	

Full-Time/Part-Time Status (check one only): Full-Time Part-Time Casual

Practice Location Category (check one only): Permanent Temporary Casual Self-Employed

Practice Setting (check one only):

Assisted Living Residence/Supportive Housing	Association/Government/Regulatory Org/Non-Government Org	Board of Health or Public Health Laboratory or Public Health Unit
Cancer Centre	Children Treatment Centres (CTC)	Client's Environment
Clinic Setting (Group)	Clinic Setting (Solo-Home Based)	Clinic Setting (Solo-Office Based)
Community Health Centre	Correctional Facility	Family Health Teams (FHTs)
Health Club	Health Related Business/Industry	Hospital
Mental Health & Addiction Facility	Nurse Practitioner Led Clinic	Other Place of Work
Post-Secondary Educational Institution	Preschool/School System/Board of Education	Rehabilitation Facility
Residential/Long-Term Care Facility	Spa	Telehealth Ontario and Telephone Health Advisory Service

Major Service Provided (check one only):

Acute Care	Areas of Administration	Areas of Consultation
Areas of Post-Secondary Education	Areas of Quality Management	Areas of Research
Areas of Sales	Cancer Care	Chronic Disease Prevention and Management
Comprehensive Primary Care	Continuing Care	Critical Care
Emergency	General Service Provision	Geriatric Care
Infectious Disease Prevention and Control	Mental Health and Addiction	Other Areas of Service/Consultation
Other Areas	Palliative Care	Primary Maternity Care
Public Health		

Primary Role (check one only):

Administrator	Manager	Salesperson
Consultant	Owner/Operator	Service Provider
Instructor/Educator	Quality Management Specialist	Researcher

Age Range of Clients (check one only):

<input type="checkbox"/>	Pediatrics 0 to 17 years	<input type="checkbox"/>	Adults 18 to 64	<input type="checkbox"/>	Adults
<input type="checkbox"/>	All ages	<input type="checkbox"/>	Seniors 65+ years		

For additional practice locations, please provide all of the above information on a separate page.

D. Communications

Preferred Address for College Communications: Home Business
Preferred Telephone Contact: Home Business Cell
Preferred Email Address: Home Business

Do you consent to the College sharing your registration number with insurers to verify your status? Yes No

Do you speak and write both English **and** French? Yes No

Are you visually impaired? Yes No

If you are visually impaired, do you need accommodation? Yes No

If you are visually impaired and require College publications in an alternate format, please select all that apply:

- Large font
- Large font with white background
- Other format(s) – Please specify: _____

Please list the languages in which you can personally and competently provide professional services **including English and/or French**:

E. Professional Registration and Practice History Outside Ontario

IMPORTANT: If you are currently registered, or have previously been registered, to practise in *any regulated profession in any jurisdiction*, please arrange to have your regulatory body send a letter confirming your current standing directly to the CMTO. Your initial registration application will not be processed until this letter has been received directly from your regulator. If you are a Massage Therapist from British Columbia, Newfoundland, or New Brunswick and a Letter of Standing has already been submitted from your regulator as part of your application under the Canadian Free Trade Agreement (CFTA), an additional letter is not required.

Are you currently registered as a Massage Therapist with another regulatory body outside of Ontario? Yes No

If yes, in which province, territory, state or country are you currently registered?

Have you ever practised Massage Therapy anywhere outside of Ontario? Yes No

If yes, in which province, territory, state or country have you practised? (Please include the dates you practised in each):

List all other professional regulators both inside and outside Ontario with which you are currently, or were previously, registered (this does not include any professional associations you may be a member of):

Are you a member of the Registered Massage Therapists' Association of Ontario (RMTAO)? Yes No

F. Education Outside of Massage Therapy

Have you completed an additional educational program other than Massage Therapy? Yes No

If yes, please indicate:

College Diploma Bachelor Master Doctorate Professional Doctorate Other

Name of Post-Secondary Institution Province, Territory, State or Country Year of Graduation

Please select your field of study:

General Rehabilitation Science	Mathematics, Computer Information Sciences	Medical Laboratory Science
Health Administration/Management	Public Administration	Kinesiology and Exercise Science
Public Health	Health Professions and Related Clinical Sciences	Gerontology
Biological and Biomedical Sciences	Psychology	Social Sciences, Arts and Humanities
Physical Sciences	Business, Management, Marketing and Related	Education
Law	Engineering	Other Field of Study

G. Professional Liability Insurance

My professional liability insurance policy includes coverage for:

_____ per occurrence and _____ aggregate per year with
Amount (per occurrence minimum is \$2,000,000) *Amount (aggregate minimum is \$5,000,000)*

a deductible of _____. My professional liability insurance is provided by
Amount (deductible must be no more than \$5,000)

_____, _____
Name of Insurance Company *Policy Number*

and is valid from _____ until _____
Effective Date (mm/dd/yyyy) *Expiry Date (mm/dd/yyyy)*

H. Eligibility to Register		
1.	I certify that I completed my Massage Therapy program within the previous three years or that I have successfully completed the CMTO Refresher Course within the last fifteen months. Alternatively, I certify that I have provided at least 500 hours of direct client care within the scope of practice of Massage Therapy within the previous three years, and that I provided that care in a regulated Canadian jurisdiction where I was registered as a Massage Therapist at the time the care was provided.	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	I understand that as a General Certificate holder, I must maintain a primary practice location in Ontario and will update my business contact information with the College within 14 days of securing or changing employment.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	I certify that I am a Canadian citizen, landed immigrant, or have a valid employment authorization from Immigration Canada to engage in the practice of the profession.	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	I certify that I have read and understood the Standards of Practice, the Code of Ethics, the College's by-laws, policies and position statements, and the <i>Massage Therapy Act, 1991</i> and its regulations.	Yes <input type="checkbox"/> No <input type="checkbox"/>

I. Offences and Investigations		
1.	Have you been found guilty of an offence under a federal, provincial or municipal law?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	Has there been a finding of professional negligence or malpractice against you? (refer to guide)	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Have you been charged, found guilty or convicted of a criminal offence or an offence under the <i>Health Insurance Act</i> or the <i>Controlled Drugs and Substances Act</i> or an offence related to the regulation of the practice of a regulated profession?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Has there been a finding of professional misconduct, incompetency or incapacity, or any like finding against you in Ontario in relation to the Massage Therapy profession or another regulated profession, or in another jurisdiction in relation to the Massage Therapy profession or another regulated profession?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	Is there a current proceeding against you involving an allegation of professional misconduct, incompetence or incapacity, or any like finding, in Ontario or in any other jurisdiction, in relation to the profession of Massage Therapy or another regulated profession?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.	Have you been charged with and found guilty of an offence, anywhere in Canada, of holding yourself out, and/or practicing, as a regulated health professional without being so registered?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7.	Are you the subject of any currently existing condition or restriction related to your custody or release, imposed by a court or other lawful authority?	Yes <input type="checkbox"/> No <input type="checkbox"/>

J. Offences and Investigations Reporting		
1.	Have the details for all findings, charges, convictions, cases and proceedings been provided to the Registration Services Department of the College? (please leave blank if you answered "No" to all of the questions in section I above as this is not applicable).	Yes <input type="checkbox"/> No <input type="checkbox"/>

K. Previous Applications or Examinations

1.	Have you ever had an unsuccessful application for registration as a Massage Therapist in Ontario or in another jurisdiction?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	Have you ever attempted to pass a professional certification, registration or licensing examination in Ontario or in another jurisdiction that has not, as of this date, resulted in a passing grade? (this does not include any unsuccessful CMTO examination attempts)	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered "Yes" to any of the questions in sections I, J or K above, please include a detailed explanation of the circumstances and any supporting documentation with this application form. This information will be reviewed by the Registrar to determine if it should be reviewed by the Registration Committee. You will be contacted by Registration Services staff if a referral to the Committee is required.

L. Privacy

1.	I acknowledge that the personal information provided on this form is used by the College to administer the <i>Regulated Health Professions Act, 1991, the Massage Therapy Act, 1991</i> , the Regulations, the By-laws, the policies, the Standards of Practice, and for research and other projects related to the governance of Massage Therapists and is collected, used, and disclosed in accordance with the College Privacy Policy.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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M. Currency and Accuracy of Information

1.	I understand that I must notify the College within fourteen days of any change of location of practice or principal practice, business name of practice, business telephone number, email address or principal residence in writing.	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	I hereby certify that all statements I have made in all parts of this form are true and complete (please note that submitting an application that you know provides false or misleading information is professional misconduct and may result in disciplinary action by the College).	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant Signature: _____ **Date:** _____

N. Credit Card Information

Please refer to the *Initial Registration Application Guide* to determine the amount to include with this application. If you are paying by credit card, fill out this section. For your security and confidentiality, credit card information will be securely destroyed after processing. If you are paying by money order or bank draft, please attach your payment to this form. Personal cheques are not accepted.

Visa MasterCard

	Amount Authorized	Credit Card Number	Expiry Date
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Name of Cardholder	Cardholder Signature
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