



**Application for Reinstatement of a Suspended Certificate of Registration
for Failure to Maintain Professional Liability Insurance**

A. Personal Information

_____	_____	_____
First Name	Last Name	Middle Initial

Registration Number	Preferred Salutation (e.g., Mr. Ms. Mrs. Miss)	

B. Home Contact Information

_____	_____	_____	_____
Street Address	City/Town	Province	Postal Code

Home Phone #	Cell Phone #	E-mail Address	

C. Business Contact Information

If you do not provide the College with business contact information, your home contact information will be deemed to be your practice location and listed on the public Register.

_____	_____
Business Name	Street Address

City/Town	Province
_____	Postal Code

Business Phone #	Business E-mail Address

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):

Pediatrics 0 to 17 years	Adults 18 to 64
All ages	Seniors 65+ years

For additional practice locations, please provide all of the above information on a separate sheet of paper

D. Communications

Preferred Mailing Address: Home Business
 Preferred Telephone Contact: Home Business Cell

E. 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*

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

F. Eligibility to Reinstate to General Certificate

1.	I certify that: <ul style="list-style-type: none"> - I completed my Massage Therapy program within the previous three years; or - I have successfully completed the CMTO Refresher Course within the last 15 months; or - I was first registered with CMTO less than two years ago; or - 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"/>

G. Offences and Investigations Since Last Renewal

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?	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, 1990</i> or the <i>Controlled Drugs and Substances Act, 1996</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 similar allegation, 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"/>

If you answered "Yes" to any of the questions in section G above, please include a detailed explanation of the circumstances and any supporting documentation with this application form. This information will be reviewed by the Professional Conduct department.

H. Privacy

I acknowledge that the personal information provided on this form is used by the College to administer the *Regulated Health Professions Act, 1991*, the *Massage Therapy Act, 1991*, 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 No

I. Currency and Accuracy of Information

1. I understand that I must notify the College in writing within 14 days of any change of location of practice or principal practice, business name of practice, business telephone number, e-mail address or principal residence.

Yes No

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 No

Signature: _____

Date: _____

J. Credit Card Information

The fee to reinstate a suspended registration for not holding Professional Liability Insurance is **\$300.00**.

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

Date of Expiry

Name of Cardholder

Cardholder Signature

Please submit your completed form by mail, fax or e-mail:

By Mail

College of Massage Therapists of Ontario
Attn: Registration Services
1867 Yonge Street, Suite 810
Toronto, ON M4S 1Y5

By Fax

416-489-2625

By E-mail

registrationservices@cmto.com