

## 2018 Status Change Form – Inactive to General Certificate (IN to GC)

### A. Personal Information

If your name has changed since you last held a General Certificate, please contact the College for information about the name change process.

First Name	Last Name	Middle Initial
Preferred Salutation (e.g., Mr. Ms. Mrs. Miss)		Registration Number

### B. Home Contact Information

Street Address	City/Town	Province	Postal Code
Home Phone #	Cell Phone #	E-mail Address	

### C. Primary Business Contact Information

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.

Business Name	Street Address	City/Town	Province	Postal Code
Phone #	Cell Phone #	E-mail Address		

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

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

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. Credit Card Information

The fee for a status change to return from an Inactive to a General Certificate in 2018 is **\$416.00**.

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 Expiry Date

\_\_\_\_\_ Name of Cardholder Signature

## F. 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)*

## G. Eligibility to hold a General Certificate

1.	I certify that: <ul style="list-style-type: none"> <li>- I completed my Massage Therapy program within the previous three years, <b><i>or</i></b></li> <li>- I have held an inactive registration with the College for less than three years, <b><i>or</i></b></li> <li>- I have successfully completed the CMTO Refresher Course within the last 15 months, <b><i>or</i></b></li> <li>- 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.</li> </ul>	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 policies and position statements, and the regulations in the <i>Massage Therapy Act, 1991</i> .	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you have performed at least 500 hours of direct client care within the scope of practice of Massage Therapy in a regulated Canadian jurisdiction within the previous three years, please list your practice locations, dates and number of weekly hours below:

Business Name and Address	Jurisdiction	Dates (From – To)	Average Weekly Hours

H. Offences and Investigations Since Last Registration/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 with, found guilty of, or convicted of a criminal offence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	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"/>
5.	Has there been a finding of professional misconduct, incompetence or incapacity, or any like finding against you, in Ontario or any other jurisdiction in relation to any regulated profession including Massage Therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.	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"/>
7.	Have you been charged with, found guilty of, or convicted 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"/>
8.	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 H, 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.

**I. 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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**J. 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 <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 information that you know provides false or misleading information is considered to be professional misconduct and may result in disciplinary action by the College.)	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**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@cmtto.com](mailto:registrationservices@cmtto.com)