College of Massage Therapists of Ontario

College of Massage Therapists of Ontario
1867 Yonge Street, Suite 810, Toronto, ON M4S 1Y5 | www.cmto.com | cmto@cmto.com
Phone 416.489.2626 | Toll-free (Ontario) 800.465.1933

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 # | Email 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 # | Email 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		Adults
	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 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 or that I first registered with CMTO less than two years ago. 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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 *Massage Therapy Act, 1991*.	Yes ☐ No ☐

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 ☐ No ☐
2.	Has there been a finding of professional negligence or malpractice against you?	Yes ☐ No ☐
3.	Have you been charged, found guilty or convicted of a criminal offence or an offence under the *Health Insurance Act, 1990* or the *Controlled Drugs and Substances Act, 1996* or an offence related to the regulation of the practice of a regulated profession?	Yes ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
6.	Have you been charged with and found guilty of an offence, anywhere in Canada, of holding yourself out, and/or practising, as a regulated professional without being registered?	Yes ☐ No ☐
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 ☐ No ☐

I. 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 H above as this is not applicable).	Yes ☐ No ☐

If you answered "Yes" to any of the questions in sections H or I above, please include a detailed explanation of the circumstances and any supporting documentation with this application form.

J. Privacy		
1.	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 ☐

K. 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:** _____