College of Massage Therapists of Ontario

College of Massage Therapists of Ontario
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2021 Status Change Form – Inactive to General Certificate (IN to GC)

Please note: If you are requesting a status change between December 15-31, it may take up to 10 business days after the new year for your request to be processed.

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. Contact details can be found at the end of this form.

First Name | Last Name | Middle Initial (if applicable)

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

Your answers to the questions in section C, D and E below will allow CMTO to determine whether you will be issued a General Certificate *AND* whether you will be authorized to practice Massage Therapy in Ontario.

C. Moving from Inactive to General Certificate (IN to GC)*		
1.	A registrant who holds an inactive certificate of registration shall, upon application, be issued a general certificate of registration if (please select one): - You have held an Inactive registration with the College for less than three years ***or***	Yes ☐ No ☐
	- You have successfully completed the CMTO Refresher Course within the last 15 months from the date of application.	Yes ☐ No ☐

D. A Registrant Must Meet ALL of the Following Requirements*		
1.	I have provided proof professional liability insurance.	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/permanent resident, or have a valid employment authorization from Immigration, Refugees and Citizenship 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 ☐

E. Authorization to Practice*		
1.	Please note a General Certificate holder is not authorized to practice unless one of the following has been met (please select one): - I have successfully completed the CMTO Refresher Course within the last 15 months, ***or*** - I have been a registrant with CMTO for less than two years, ***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 ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

***To be eligible for a General Certificate and be authorized to practice you must answer "Yes" to one of the questions in section C, answer "Yes" to *all* the questions in section D and answer "Yes" to at least one of the questions in section E.**

If you are unable to answer "Yes" to any of the questions in section E, you will be issued a General Certificate, but you will not be authorized to practice. This means you will hold a General Certificate, but you cannot practise Massage Therapy in the province of Ontario.

F. Primary Business Contact Information

If you have not provided the College with a business address, your home address will be considered your practice location and listed on the public register.

Business Name | Street Address | City/Town | Province | Postal Code

Work Phone # | Cell Phone # | E-mail Address

Full-Time/Part-Time Status (check one only): Full Time (30 or more hours) ☐ Part-Time (less than 30 hours) ☐ 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	☐	Telehealth Ontario and Telephone Health Advisory Service
☐	Post-Secondary Educational Institution	☐	Preschool/School System/Board of Education	☐	Rehabilitation Facility
☐	Residential/Long-Term Care Facility	☐	Spa	☐	Other Place of Work

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	☐	Primary Maternity Care
☐	Public Health	☐	Palliative Care	☐	Other Areas of Service/Consultation
☐	Other Areas				

Primary Role (check one only):

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

Age Range of Clients (check the age range that is applicable to the greatest number of clients):

☐	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.

G. Communications

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

H. 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)*

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 (i.e. in Newfoundland, New Brunswick, Prince Edwards Island or British Columbia) within the previous three years, please list your practice locations, dates and number of weekly hours below:

Business Name and Address	Province	**Dates (From – To) YYYY/MM/DD**	**Average Weekly Hours**

I. Declarations and Authorization		
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 ☐
2.	I understand that I must notify the College within 14 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 ☐ No ☐
3.	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 for a status change from an Inactive to a General Certificate in 2021 is **$585.00**.

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. CMTO does **not** accept cash or personal cheques.

Visa ☐ MasterCard ☐

Amount Authorized | Credit Card Number | Expiry Date

Name of Cardholder | Signature

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

By Mail	**By Fax**	**By E-mail**
College of Massage Therapists of Ontario Attn: Registration Services 1867 Yonge Street, Suite 810 Toronto, ON M4S 1Y5	416-489-2625	registrationservices@cmto.com