



2021 Application for Reinstatement of a Suspended Certificate of Registration for Non-Payment of the Second Installment of the 2021 General Certificate Renewal Fees

Please select one:

I am applying for reinstatement of a General Certificate (GC)

OR

I am applying for reinstatement of an Inactive Certificate (IN)

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 have not provided the College with a business address, your home address will be deemed to be your practice location and will be listed on the public register (Find an RMT) on the College website. If you have additional practice locations, please provide all of the following information for each practice location on a separate sheet of paper.

Business Name Street Address

City/Town Province Postal Code

Business Phone # Business Email 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
Seniors 65+ Years	All Ages

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

D. Communications

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

E. Professional Liability Insurance (for General Certificate only)

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)*

F. Eligibility to Reinstate to General Certificate (for GC only)

1.	I have provided at least 500 hours of direct client care within the scope of practice of Massage Therapy within the previous three years, or I will have provided at least 500 hours of direct client care within the scope of practice of Massage Therapy by March 29, 2021 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; OR	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2.	I have successfully completed the CMTO Refresher Course within the last 15 months; OR	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.	I have been registered with CMTO for less than two years ago.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.	I understand that I must always maintain professional liability insurance (PLI) while holding a general certificate of registration.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5.	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"/>
6.	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"/>
7.	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"/>
8.	I am aware of and understand my responsibilities as a regulated health professional and a Registered Massage Therapist regarding the prevention of sexual abuse of clients, including the provisions of CMTO's Standard for Maintaining Professional Boundaries and Preventing Sexual Abuse .	Yes <input type="checkbox"/>	No <input type="checkbox"/>

OR

G. Eligibility to Reinstate to Inactive Certificate (for IN only)		
1.	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"/>
2.	I hereby certify that I will not practise as a Massage Therapist in Ontario during the term of my Inactive Certificate and that if I do decide to return to practice in Ontario, I will apply to the College of Massage Therapists of Ontario for a General Certificate of registration.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	I acknowledge that it is professional misconduct to practise Massage Therapy while holding an Inactive Certificate or while suspended. I understand that signing receipts for Massage Therapy while Inactive or suspended may be considered insurance fraud and that the College will investigate complaints and may take further action.	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	I am aware of and understand my responsibilities as a regulated health professional and a Registered Massage Therapist regarding the prevention of sexual abuse of clients, including the provisions of CMTO's Standard for Maintaining Professional Boundaries and Preventing Sexual Abuse .	Yes <input type="checkbox"/> No <input type="checkbox"/>

H. Acupuncture in Massage Therapy Practice		
1.	Are you using acupuncture in your Massage Therapy practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>

I. Using Acupuncture in Massage Therapy Practice		
If you answered Yes to the question in section H above, please review the following statements and respond to each declaration:		
1.	I have read and understood the College's Standards of Practice, including the Standard of Practice for Acupuncture, and the Acupuncture Practice Competencies and Performance Indicators, and am aware of how they would apply to my performance of acupuncture.	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	I have read and understood the College's regulations and am aware of how they would apply to my performance of acupuncture.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	I will practice acupuncture only within the Scope of Practice for Massage Therapy.	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	I have the appropriate knowledge, skill and judgement to perform acupuncture within the Scope of Practice for Massage Therapy.	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	I understand that being on the College acupuncture roster may result in being selected for Quality Assurance practice assessments on a more frequent basis than non-rostered persons.	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.	I understand that if a practice assessment, audit or investigation demonstrates that my knowledge, skill or judgment to perform acupuncture is unsatisfactory I may be temporarily or permanently removed from the acupuncture roster and would not be permitted to perform acupuncture.	Yes <input type="checkbox"/> No <input type="checkbox"/>
7.	I declare that my professional liability insurance includes coverage of acupuncture in my Massage Therapy practice.	Yes <input type="checkbox"/> No <input type="checkbox"/>
8.	I hereby certify and declare that I have read, understood, and comply with each of the above seven statements regarding my acupuncture practice.	Yes <input type="checkbox"/> No <input type="checkbox"/>

J. Conduct*		
Since your 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 with, found guilty of, or convicted of a criminal offence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Have you been charged with, found guilty of, or convicted of an offence under the <i>Health Insurance Act</i> , the <i>Controlled Drugs and Substances Act</i> or an offence related to 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 any other jurisdiction in relation to any regulated profession including Massage Therapy?	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 J 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.**

K. Declarations and Authorization		
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</i> , the <i>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"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>

Signature: _____

Date: _____

L. Fees and Credit Card Information

Please refer to the fees below and be sure to include the correct amount to avoid processing delays:

General Certificate (GC) Reinstatement Fees:

Certificate suspended in 2021: Reinstate to General Certificate	
Reinstatement Fee	\$300.00
2021 GC Fee Second Payment	\$392.50
TOTAL AMOUNT DUE:	\$692.50

Inactive (IN) Certificate Reinstatement Fees:

Certificate suspended in 2021: Reinstate to Inactive Certificate	
Reinstatement Fee	\$300.00
2021 GC Fee Second Payment	\$392.50
TOTAL AMOUNT DUE:	\$692.50

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 and submit it by mail. CMTO does **not** accept cash or personal cheques.

Visa MasterCard

Amount Authorized

Credit Card Number

Expiry Date

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@cmta.com