College of Massage Therapists of Ontario

College of Massage Therapists of Ontario
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Phone 416.489.2626 | Toll-free (Ontario) 800.465.1933

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

Please select one:

❑ I am applying for reinstatement of a General Certificate (GC).
(You must submit a copy of your *Certificate of Insurance* with this application.)
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 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
	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 (Please leave blank if reinstating to Inactive)

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 (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 ☐ No ☐
2.	I have successfully completed the CMTO Refresher Course within the last 15 months; **OR**	Yes ☐ No ☐
3.	I have been registered with CMTO for less than two years ago.	Yes ☐ No ☐
4.	I understand that I must always maintain professional liability insurance (PLI) while holding a general certificate of registration.	Yes ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 *Massage Therapy Act, 1991* and its regulations.	Yes ☐ No ☐
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 ☐ No ☐

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 *Massage Therapy Act*, *1991* and its regulations.	Yes ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐

H. Acupuncture in Massage Therapy Practice		
1.	Are you using acupuncture in your Massage Therapy practice?	Yes ☐ No ☐

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 ☐ No ☐
2.	I have read and understood the College's regulations and am aware of how they would apply to my performance of acupuncture.	Yes ☐ No ☐
3.	I will practice acupuncture only within the Scope of Practice for Massage Therapy.	Yes ☐ No ☐
4.	I have the appropriate knowledge, skill and judgement to perform acupuncture within the Scope of Practice for Massage Therapy.	Yes ☐ No ☐
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 that non-rostered persons.	Yes ☐ No ☐
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 ☐ No ☐
7.	I declare that my professional liability insurance includes coverage of acupuncture in my Massage Therapy practice.	Yes ☐ No ☐
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 ☐ No ☐

J. Conduct*		
Since your last 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 with, found guilty of, or convicted of a criminal offence?	Yes ☐ No ☐
4.	Have you been charged with, found guilty of, or convicted of an offence under the *Health Insurance Act,* the *Controlled Drugs and Substances Act* or an offence related to the practice of a regulated profession?	Yes ☐ No ☐

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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐
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 ☐ No ☐

***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 *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:** _____

L. 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 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	**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