



ANNUAL REGISTRATION RENEWAL IS DUE JUNE 1, 2010

Review the Annual Registration Renewal Guide for assistance. The Guide is available on the College website at www.coto.org > Registration > Annual Registration Renewal.

You are encouraged to renew your registration online at www.coto.org > Registration > Annual Registration Renewal.

Login to view your online form which will contain all of your data currently on file with the College.

SECTION 1 - GENERAL INFORMATION

Form with fields for: Legal First Name, Legal Last Name, Middle name, Commonly Used FIRST Name in Practice, Previous Legal First Name, Commonly Used LAST Name in Practice, Previous Legal Last Name, Home Address, City, Province/Territory, Country, Postal Code, Preferred Mailing Address, Telephone, Preferred E-mail Address.

Languages of Service

Provide up to five languages in which you can personally and competently provide professional services.

Form with five numbered lines (1) through (5) for listing languages of service.

SECTION 2 - NOT RENEWING / CANCELLING REGISTRATION

I wish to cancel my certificate of registration with the College and I declare that I will not be practising and/or using title as OT in Ontario after May 31, 2010. I understand that it is my responsibility to contact the College to obtain a certificate of registration prior to resuming practice or using OT title in Ontario. I understand that I will be subject to the registration requirements at the time of my application.

Form with fields for: Last day of OT employment, Signature

Please indicate the reason for cancelling your certificate of registration:

- Leaving the country, Leaving the province, Leave, Changing profession, Return to School, Retiring, Other

**SECTION 3 - CURRENCY HOURS** *(If this section is not completed, your form will be returned to you)*Please check  in the first box that demonstrates you meet this requirement:

- |   |  |
|---|--|
| <input type="checkbox"/> In the past three years I have worked at least 750 hours | <input type="checkbox"/> I graduated within the past 18 months   |
| <input type="checkbox"/> In the past five years I have worked at least 1550 hours | <input type="checkbox"/> I registered in Ontario under the Labour Mobility Support Agreement (LMSA) within the past year |
| <input type="checkbox"/> I completed a re-entry program within the past 18 months | <input type="checkbox"/> I do NOT meet any of the above currency requirements and require a review                       |

**SECTION 4 - EDUCATION RELATED TO YOUR OT PROFESSIONAL QUALIFICATIONS**If you have completed additional occupational therapy education since **last year's renewal/registration**, please complete the section below.

- |   |  |
|---|--|
| <input type="checkbox"/> Diploma              | <input type="checkbox"/> Doctorate                                 |
| <input type="checkbox"/> Baccalaureate        | <input type="checkbox"/> Professional Doctorate                    |
| <input type="checkbox"/> Masters              | <input type="checkbox"/> Other                                     |
| <input type="checkbox"/> Professional Masters | <input type="checkbox"/> Not Applicable <i>(Skip to Section 5)</i> |

Canadian University (specify) \_\_\_\_\_ Province \_\_\_\_\_ Year Graduated \_\_\_\_\_  
(Name of university) (YYYY)

Out of Country University (specify) \_\_\_\_\_ State, Country \_\_\_\_\_ Year Graduated \_\_\_\_\_  
(Name of university) (YYYY)

**SECTION 5 - EDUCATION OTHER THAN OT**If you have completed education other than occupational therapy education **since last year's renewal/registration**, please complete the section below.

- |   |  |
|---|--|
| <input type="checkbox"/> Diploma              | <input type="checkbox"/> Doctorate                                 |
| <input type="checkbox"/> Baccalaureate        | <input type="checkbox"/> Professional Doctorate                    |
| <input type="checkbox"/> Masters              | <input type="checkbox"/> Other                                     |
| <input type="checkbox"/> Professional Masters | <input type="checkbox"/> Not Applicable <i>(Skip to Section 6)</i> |

Canadian University (specify) \_\_\_\_\_ Province \_\_\_\_\_ Year Graduated \_\_\_\_\_  
(Name of university) (YYYY)

Out of Country University (specify) \_\_\_\_\_ State, Country \_\_\_\_\_ Year Graduated \_\_\_\_\_  
(Name of university) (YYYY)

SELECT THE FIELD OF STUDY FOR ADDITIONAL EDUCATION COMPLETED UNRELATED TO OT QUALIFICATIONS *(Refer to the Guide for full definitions.)*

- |   |  |
|---|--|
| <input type="checkbox"/> General Rehabilitation Science                   | <input type="checkbox"/> Biological and Biomedical Sciences          |
| <input type="checkbox"/> Mathematics, Computer Information Sciences       | <input type="checkbox"/> Psychology                                  |
| <input type="checkbox"/> Medical Laboratory Science                       | <input type="checkbox"/> Social Sciences, Arts and Humanities        |
| <input type="checkbox"/> Health Administration/Management                 | <input type="checkbox"/> Physical Sciences                           |
| <input type="checkbox"/> Public Administration                            | <input type="checkbox"/> Business, Management, Marketing and Related |
| <input type="checkbox"/> Kinesiology and Exercise Science                 | <input type="checkbox"/> Education                                   |
| <input type="checkbox"/> Public Health                                    | <input type="checkbox"/> Law   |
| <input type="checkbox"/> Health Professions and Related Clinical Sciences | <input type="checkbox"/> Engineering                                 |
| <input type="checkbox"/> Gerontology                                      | <input type="checkbox"/> Other Field of Study                        |

**SECTION 6 - PRACTICE STATUS**

WHAT IS YOUR PRACTICE STATUS? *(Please select only one)*

- Employed in OT
- Employed, on leave
- Unemployed and seeking employment in OT
- Unemployed and not seeking employment in OT
- Working outside of profession and seeking work in OT
- Working outside of profession and not seeking work in OT

Leave Start Date <i>(dd/mm/yy)</i>	Leave End Date <i>(if applicable)</i>
------------------------------------	---------------------------------------

**SECTION 7 - CURRENT EMPLOYMENT**

Complete this section if you are currently practising occupational therapy in some capacity or if you have practised in the last 12 months. Answers should reflect your situation across all sites of practice.

Yes  No Did you provide student supervision for more than three weeks in the last year?

Yes  No Do you plan to provide student supervision this coming year?

Yes  No Do you have clinical clients – even if just 1?

Enter the **number of weeks** you spent practising your profession in the past 12 months across all of your practice sites or jobs.  
*(Note: one practice day in any week = one week of practice; exclude your vacation, on-call, sick and leave time greater than one week; there are 52 weeks in one calendar year.)*

\_\_\_\_\_

Enter the **average number of hours** spent practising **per week** in the past 12 months across all of your practice sites or jobs.  
*(Note: hours should be inclusive of all practice hours; e.g. travel time between practice settings, preparation and service provision. Hours should exclude commuting and any time spent volunteering outside of the profession.)*

\_\_\_\_\_

Please check which best describes the nature of your practice:

- Primarily clinical practice**  
A clinical OT is a registered OT who uses OT knowledge and skills to provide direct service to clients/patients.
- Primarily non-clinical**  
A non-clinical OT is a registered OT who uses OT knowledge and skill, and does not provide direct service to clients, who is accountable to the public through the College.
- Mixed Nature**  
An OT with a mixed nature of practice has primarily a non-clinical nature of practice but provides direct service to clients as well.

Please note the definition of a client: The College has defined a client as an individual (or group of individuals) or the client's authorized representative, whose occupational performance issue(s) has resulted in a request for occupational therapy services.

Of your weekly practice hours, please provide the proportion you spend on each activity, adding to 100%	Percentage
a) Time spent on direct professional services <i>(time spent per week on direct OT professional services e.g. conducting tests, client care, charting on clients, health promotion)</i>	_____ %
b) Time spent teaching <i>(time spent per week teaching to prepare students for the OT profession including clinical education)</i>	_____ %
c) Time spent on research	_____ %
d) Time spent on administration <i>(time spent per week planning, organizing, management, paperwork - stats, billing)</i>	_____ %
e) Time spent on all other activities <i>(time spent per week on activities excluding direct professional services, teaching, research and administration)</i>	_____ %
<b>TOTAL (a+b+c+d+e)</b>	<b>100 %</b>

**SECTION 8 - CURRENT EMPLOYMENT PROFILE—PRACTICE SITE INFORMATION**

If you provide professional services at more than one practice site or for more than one employer then complete up to three practice profiles, as needed.

 Yes  No Are you practising at more than three practice sites or do you have more than three employers?
**8.1 PRACTICE SITE 1 - PRIMARY EMPLOYMENT** (For each section below, please choose the one descriptor that best represents the majority of your work.)

Employer Name		Postal Code
Address		Country
City		Telephone ( )
Province	Start Date	Fax ( )
		Postal Code reflects site of practice <input type="checkbox"/> Yes <input type="checkbox"/> No

WHAT IS YOUR **EMPLOYMENT RELATIONSHIP** AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- Permanent (indeterminate duration of employment and guaranteed or fixed practice hours per week)
- Temporary (fixed duration of employment, based on a defined start and end date)
- Casual (on an as-needed basis)
- Self-employed (a person who operates his or her own economic enterprise in occupational therapy)

WHAT IS YOUR **EMPLOYMENT STATUS** AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- Full-Time (your usual hours of practise are 30 hours or more per week or this is your official status with your employer)  
\_\_\_\_\_ Enter approximate number of hours worked per week
- Part-Time (your usual hours of practise are less than 30 hours per week or this is your official status with your employer)  
\_\_\_\_\_ Enter approximate/average number of hours worked per week
- Casual (your official status with your employer is on an as-needed basis)  
\_\_\_\_\_ Enter approximate/average number of hours worked per week

WHAT IS YOUR **PRIMARY PRACTICE SETTING** AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |   |   |
|---|---|
| <input type="checkbox"/> General Hospital                             | <input type="checkbox"/> Group Professional Practice Office/Clinic  |
| <input type="checkbox"/> Rehabilitation Facility/Hospital             | <input type="checkbox"/> Solo Practice Office   |
| <input type="checkbox"/> Children Treatment Centre (CTC)              | <input type="checkbox"/> Post-Secondary Educational Institution   |
| <input type="checkbox"/> Mental Health and Addiction Facility         | <input type="checkbox"/> Preschool/School System/Board of Education   |
| <input type="checkbox"/> Residential/Long-Term Care Facility          | <input type="checkbox"/> Health Related Business/Industry   |
| <input type="checkbox"/> Assisted Living Residence/Supportive Housing | <input type="checkbox"/> Group Health Centre (Sault St. Marie)  |
| <input type="checkbox"/> Community Health Centre (CHC)                | <input type="checkbox"/> Cancer Centre  |
| <input type="checkbox"/> Community Care Access Centre (CCAC)          | <input type="checkbox"/> TeleHealth Ontario or other Telephone Health Advisory Services                               |
| <input type="checkbox"/> Visiting Agency/Client's Environment         | <input type="checkbox"/> Board of Health/Public Health Laboratory/Public Health Unit                                  |
| <input type="checkbox"/> Family Health Team (FHT)                     | <input type="checkbox"/> Association/Government/Regulatory Organization/Non-Government Organization (e.g. MS Society) |
| <input type="checkbox"/> Independent Health Facility                  | <input type="checkbox"/> Other Place of Work  |
| <input type="checkbox"/> Nurse Practitioner-Led Clinic                |   |

WHAT IS YOUR **PRIMARY ROLE** AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |   |  |
|---|--|
| <input type="checkbox"/> Administrator                          | <input type="checkbox"/> Consultant (non-client care)  |
| <input type="checkbox"/> Manager                                | <input type="checkbox"/> Instructor/Educator           |
| <input type="checkbox"/> Owner/Operator                         | <input type="checkbox"/> Researcher                    |
| <input type="checkbox"/> Service Provider – Direct Care         | <input type="checkbox"/> Salesperson                   |
| <input type="checkbox"/> Service Provider – Professional Leader | <input type="checkbox"/> Quality Management Specialist |

WHAT IS THE ONE MAJOR SERVICE THAT YOU PROVIDE AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |  |  |
|--|--|
| <input type="checkbox"/> Mental Health and Addiction               | <input type="checkbox"/> Vocational Rehabilitation                 |
| <input type="checkbox"/> Palliative Care                           | <input type="checkbox"/> Consultation                              |
| <input type="checkbox"/> General Service Provision                 | <input type="checkbox"/> Sales                                     |
| <input type="checkbox"/> Chronic Disease Prevention and Management | <input type="checkbox"/> Administration                            |
| <input type="checkbox"/> Comprehensive Primary Care                | <input type="checkbox"/> Other Area of Direct Service/Consultation |
| <input type="checkbox"/> Quality Management                        | <input type="checkbox"/> Other Areas                               |
| <input type="checkbox"/> Cancer Care                               | <input type="checkbox"/> *Critical Care                            |
| <input type="checkbox"/> Post-Secondary Education                  | <input type="checkbox"/> *Acute Care                               |
| <input type="checkbox"/> Public Health                             | <input type="checkbox"/> *Continuing Care                          |
| <input type="checkbox"/> Research                                  | <input type="checkbox"/> *Geriatric Care                           |
| <input type="checkbox"/> Client Services Management                |  |

If you select one of the services marked with an asterisk (\*), please indicate the primary health condition as described below (only select one).

Neurological

Cardiovascular & Respiratory

Musculoskeletal

Digestive/Metabolic/Endocrine

WHAT IS THE MAIN AGE RANGE OF YOUR CLIENTS AT THIS PRACTICE SITE?

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Preschool (0-4)          | <input type="checkbox"/> School Age (5-17) | <input type="checkbox"/> Seniors (65+)         | <input type="checkbox"/> All Ages       |
| <input type="checkbox"/> Mixed Paediatrics (0-17) | <input type="checkbox"/> Adults (18-64)    | <input type="checkbox"/> Mixed Adults (18-65+) | <input type="checkbox"/> Not Applicable |

FUNDING SOURCE

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Public/Government                | <input type="checkbox"/> Public/Private mix   | <input type="checkbox"/> Auto Insurance  |
| <input type="checkbox"/> Private Sector/Individual Client | <input type="checkbox"/> Other funding source | <input type="checkbox"/> Other Insurance |

**8.2 PRACTICE SITE 2 - SECONDARY EMPLOYMENT** (For each section below, please choose the one descriptor that best represents the majority of your work.)

Employer Name		Postal Code
Address		Country
City		Telephone (     )
Province		Fax (     )
Start Date	Postal Code reflects site of practice <input type="checkbox"/> Yes <input type="checkbox"/> No	

WHAT IS YOUR EMPLOYMENT RELATIONSHIP AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- Permanent (indeterminate duration of employment and guaranteed or fixed practice hours per week)
- Temporary (fixed duration of employment, based on a defined start and end date)
- Casual (on an as-needed basis)
- Self-employed (a person who operates his or her own economic enterprise in occupational therapy)

WHAT IS YOUR EMPLOYMENT STATUS AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- Full-Time (your usual hours of practise are 30 hours or more per week or this is your official status with your employer)  
\_\_\_\_\_ Enter approximate number of hours worked per week
- Part-Time (your usual hours of practise are less than 30 hours per week or this is your official status with your employer)  
\_\_\_\_\_ Enter approximate/average number of hours worked per week
- Casual (your official status with your employer is on an as-needed basis)  
\_\_\_\_\_ Enter approximate/average number of hours worked per week

WHAT IS YOUR **PRIMARY PRACTICE SETTING** AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |   |   |
|---|---|
| <input type="checkbox"/> General Hospital                             | <input type="checkbox"/> Group Professional Practice Office/Clinic  |
| <input type="checkbox"/> Rehabilitation Facility/Hospital             | <input type="checkbox"/> Solo Practice Office   |
| <input type="checkbox"/> Children Treatment Centre (CTC)              | <input type="checkbox"/> Post-Secondary Educational Institution   |
| <input type="checkbox"/> Mental Health and Addiction Facility         | <input type="checkbox"/> Preschool/School System/Board of Education   |
| <input type="checkbox"/> Residential/Long-Term Care Facility          | <input type="checkbox"/> Health Related Business/Industry   |
| <input type="checkbox"/> Assisted Living Residence/Supportive Housing | <input type="checkbox"/> Group Health Centre (Sault St. Marie)  |
| <input type="checkbox"/> Community Health Centre (CHC)                | <input type="checkbox"/> Cancer Centre  |
| <input type="checkbox"/> Community Care Access Centre (CCAC)          | <input type="checkbox"/> TeleHealth Ontario or other Telephone Health Advisory Services                               |
| <input type="checkbox"/> Visiting Agency/Client's Environment         | <input type="checkbox"/> Board of Health/Public Health Laboratory/Public Health Unit                                  |
| <input type="checkbox"/> Family Health Team (FHT)                     | <input type="checkbox"/> Association/Government/Regulatory Organization/Non-Government Organization (e.g. MS Society) |
| <input type="checkbox"/> Independent Health Facility                  | <input type="checkbox"/> Other Place of Work  |
| <input type="checkbox"/> Nurse Practitioner-Led Clinic                |   |

WHAT IS YOUR **PRIMARY ROLE** AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |   |  |
|---|--|
| <input type="checkbox"/> Administrator                          | <input type="checkbox"/> Consultant (non-client care)  |
| <input type="checkbox"/> Manager                                | <input type="checkbox"/> Instructor/Educator           |
| <input type="checkbox"/> Owner/Operator                         | <input type="checkbox"/> Researcher                    |
| <input type="checkbox"/> Service Provider – Direct Care         | <input type="checkbox"/> Salesperson                   |
| <input type="checkbox"/> Service Provider – Professional Leader | <input type="checkbox"/> Quality Management Specialist |

WHAT ARE THE **MAJOR SERVICES** THAT YOU PROVIDE AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |  |  |
|--|--|
| <input type="checkbox"/> Mental Health and Addiction               | <input type="checkbox"/> Vocational Rehabilitation                 |
| <input type="checkbox"/> Palliative Care                           | <input type="checkbox"/> Consultation                              |
| <input type="checkbox"/> General Service Provision                 | <input type="checkbox"/> Sales                                     |
| <input type="checkbox"/> Chronic Disease Prevention and Management | <input type="checkbox"/> Administration                            |
| <input type="checkbox"/> Comprehensive Primary Care                | <input type="checkbox"/> Other Area of Direct Service/Consultation |
| <input type="checkbox"/> Quality Management                        | <input type="checkbox"/> Other Areas                               |
| <input type="checkbox"/> Cancer Care                               | <input type="checkbox"/> *Critical Care                            |
| <input type="checkbox"/> Post-Secondary Education                  | <input type="checkbox"/> *Acute Care                               |
| <input type="checkbox"/> Public Health                             | <input type="checkbox"/> *Continuing Care                          |
| <input type="checkbox"/> Research                                  | <input type="checkbox"/> *Geriatric Care                           |
| <input type="checkbox"/> Client Services Management                |  |

If you select one of the services marked with an asterisk (\*), please indicate the primary health condition as described below (only select one).

- |  |
|--|
| <input type="checkbox"/> Neurological                  |
| <input type="checkbox"/> Cardiovascular & Respiratory  |
| <input type="checkbox"/> Musculoskeletal               |
| <input type="checkbox"/> Digestive/Metabolic/Endocrine |

WHAT IS THE **MAIN AGE RANGE** OF YOUR CLIENTS AT THIS PRACTICE SITE?

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Preschool (0-4)          | <input type="checkbox"/> School Age (5-17) | <input type="checkbox"/> Seniors (65+)         | <input type="checkbox"/> All Ages       |
| <input type="checkbox"/> Mixed Paediatrics (0-17) | <input type="checkbox"/> Adults (18-64)    | <input type="checkbox"/> Mixed Adults (18-65+) | <input type="checkbox"/> Not Applicable |

FUNDING SOURCE

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Public/Government                | <input type="checkbox"/> Public/Private mix   | <input type="checkbox"/> Auto Insurance  |
| <input type="checkbox"/> Private Sector/Individual Client | <input type="checkbox"/> Other funding source | <input type="checkbox"/> Other Insurance |

## 8.3 PRACTICE SITE 3 - TERTIARY EMPLOYMENT (For each section below, please choose the one descriptor that best represents the majority of your work.)

Employer Name	Postal Code
Address	Country
	Telephone (      )
City	Fax (      )
Province	Postal Code reflects site of practice <input type="checkbox"/> Yes <input type="checkbox"/> No

## WHAT IS YOUR EMPLOYMENT RELATIONSHIP AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- Permanent (indeterminate duration of employment and guaranteed or fixed practice hours per week)
- Temporary (fixed duration of employment, based on a defined start and end date)
- Casual (on an as-needed basis)
- Self-employed (a person who operates his or her own economic enterprise in occupational therapy)

## WHAT IS YOUR EMPLOYMENT STATUS AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- Full-Time (your usual hours of practise are 30 hours or more per week or this is your official status with your employer)  
\_\_\_\_\_ Enter approximate number of hours worked per week
- Part-Time (your usual hours of practise are less than 30 hours per week or this is your official status with your employer)  
\_\_\_\_\_ Enter approximate/average number of hours worked per week
- Casual (your official status with your employer is on an as-needed basis)  
\_\_\_\_\_ Enter approximate/average number of hours worked per week

## WHAT IS YOUR PRIMARY PRACTICE SETTING AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |   |   |
|---|---|
| <input type="checkbox"/> General Hospital                             | <input type="checkbox"/> Group Professional Practice Office/Clinic  |
| <input type="checkbox"/> Rehabilitation Facility/Hospital             | <input type="checkbox"/> Solo Practice Office   |
| <input type="checkbox"/> Children Treatment Centre (CTC)              | <input type="checkbox"/> Post-Secondary Educational Institution   |
| <input type="checkbox"/> Mental Health and Addiction Facility         | <input type="checkbox"/> Preschool/School System/Board of Education   |
| <input type="checkbox"/> Residential/Long-Term Care Facility          | <input type="checkbox"/> Health Related Business/Industry   |
| <input type="checkbox"/> Assisted Living Residence/Supportive Housing | <input type="checkbox"/> Group Health Centre (Sault St. Marie)  |
| <input type="checkbox"/> Community Health Centre (CHC)                | <input type="checkbox"/> Cancer Centre  |
| <input type="checkbox"/> Community Care Access Centre (CCAC)          | <input type="checkbox"/> TeleHealth Ontario or other Telephone Health Advisory Services                               |
| <input type="checkbox"/> Visiting Agency/Client's Environment         | <input type="checkbox"/> Board of Health/Public Health Laboratory/Public Health Unit                                  |
| <input type="checkbox"/> Family Health Team (FHT)                     | <input type="checkbox"/> Association/Government/Regulatory Organization/Non-Government Organization (e.g. MS Society) |
| <input type="checkbox"/> Independent Health Facility                  | <input type="checkbox"/> Other Place of Work  |
| <input type="checkbox"/> Nurse Practitioner-Led Clinic                |   |

## WHAT IS YOUR PRIMARY ROLE AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |   |  |
|---|--|
| <input type="checkbox"/> Administrator                          | <input type="checkbox"/> Consultant (non-client care)  |
| <input type="checkbox"/> Manager                                | <input type="checkbox"/> Instructor/Educator           |
| <input type="checkbox"/> Owner/Operator                         | <input type="checkbox"/> Researcher                    |
| <input type="checkbox"/> Service Provider – Direct Care         | <input type="checkbox"/> Salesperson                   |
| <input type="checkbox"/> Service Provider – Professional Leader | <input type="checkbox"/> Quality Management Specialist |

WHAT ARE THE MAJOR SERVICES THAT YOU PROVIDE AT THIS PRACTICE SITE? (Refer to the Guide for full definitions.)

- |  |  |
|--|--|
| <input type="checkbox"/> Mental Health and Addiction               | <input type="checkbox"/> Vocational Rehabilitation                 |
| <input type="checkbox"/> Palliative Care                           | <input type="checkbox"/> Consultation                              |
| <input type="checkbox"/> General Service Provision                 | <input type="checkbox"/> Sales                                     |
| <input type="checkbox"/> Chronic Disease Prevention and Management | <input type="checkbox"/> Administration                            |
| <input type="checkbox"/> Comprehensive Primary Care                | <input type="checkbox"/> Other Area of Direct Service/Consultation |
| <input type="checkbox"/> Quality Management                        | <input type="checkbox"/> Other Areas                               |
| <input type="checkbox"/> Cancer Care                               | <input type="checkbox"/> *Critical Care                            |
| <input type="checkbox"/> Post-Secondary Education                  | <input type="checkbox"/> *Acute Care                               |
| <input type="checkbox"/> Public Health                             | <input type="checkbox"/> *Continuing Care                          |
| <input type="checkbox"/> Research                                  | <input type="checkbox"/> *Geriatric Care                           |
| <input type="checkbox"/> Client Services Management                |  |

If you select one of the services marked with an asterisk (\*), please indicate the primary health condition as described below (only select one).

Neurological

Cardiovascular & Respiratory

Musculoskeletal

Digestive/Metabolic/Endocrine

WHAT IS THE MAIN AGE RANGE OF YOUR CLIENTS AT THIS PRACTICE SITE?

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Preschool (0-4)          | <input type="checkbox"/> School Age (5-17) | <input type="checkbox"/> Seniors (65+)         | <input type="checkbox"/> All Ages       |
| <input type="checkbox"/> Mixed Paediatrics (0-17) | <input type="checkbox"/> Adults (18-64)    | <input type="checkbox"/> Mixed Adults (18-65+) | <input type="checkbox"/> Not Applicable |

FUNDING SOURCE

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Public/Government                | <input type="checkbox"/> Public/Private mix   | <input type="checkbox"/> Auto Insurance  |
| <input type="checkbox"/> Private Sector/Individual Client | <input type="checkbox"/> Other funding source | <input type="checkbox"/> Other Insurance |

**SECTION 9 - CONDUCT AND PROFESSIONAL REGISTRATION**

All the following questions (a - p) must be answered. If you answer “yes” to any of these questions, please provide details in Section 12 or attach additional information.

- a)  Yes  No Have you ever been refused registration in an occupational therapy body that has not previously been reported to the College?
- b)  Yes  No Have you had a finding of, or are you currently facing a proceeding for, professional misconduct, incompetency, incapacity or a similar issue as an OT in another jurisdiction, that has not been previously reported to the College?
- c)  Yes  No Have you had a finding of, or are you currently facing a proceeding for professional misconduct, incompetency, incapacity or a similar issue in another profession other than OT in Ontario or elsewhere, that has not been previously reported to the College?
- d)  Yes  No Have you been found guilty of an offence related to the practice of occupational therapy that has not been previously reported to the College?
- e)  Yes  No Have you been found guilty of an offense that has not been previously reported to the College?
- f)  Yes  No Is there anything else in your previous conduct that would afford reasonable grounds for the belief that you lack the knowledge, skill, judgement to practise safely and ethically?
- g)  Yes  No Are you currently registered/licensed to practice as an occupational therapist in other provinces/states/countries? (If yes, you must provide all details required below. Use a separate sheet of paper if required.)

Regulatory Body	Province/State	Country	License/ Registration Number	Expiry Date (dd/mm/yy)

- h)  Yes  No Are you currently registered/licensed to practice in another profession other than OT in Ontario or elsewhere? (If yes, you must provide all details required below. Use a separate sheet of paper if required.)

Name of Profession: \_\_\_\_\_

Regulatory Body	Province/State	Country	License/ Registration Number	Expiry Date (dd/mm/yy)

- i) Most recent previous country of practice \_\_\_\_\_.
- j) Most recent previous province/territory of practice outside of Ontario \_\_\_\_\_.
- k) Most recent year of practice in previous jurisdiction outside of Ontario \_\_\_\_\_.
- l) Country of first time practising in OT \_\_\_\_\_.
- m) Province/Territory/State of first time practising in OT (outside of Ontario) \_\_\_\_\_.
- n) First year practising in OT (in or outside of Ontario) \_\_\_\_\_.
- o) First Canadian province of practise in OT \_\_\_\_\_.
- p) Year of first Canadian practise in OT \_\_\_\_\_.

**SECTION 10 - PROFESSIONAL LIABILITY INSURANCE**

To renew your certificate you must hold professional liability insurance as prescribed by the College Bylaws, Section 20 regardless of your employment status. Provide all the information requested below. If you do not have professional liability insurance, you do not meet the requirements and are not eligible to renew your registration certificate until this mandatory requirement has been met.

Yes  No Do you have professional liability insurance?

Plan Held Through	Expiry Date (dd/mm/yy)	Certificate Number

**SECTION 11 - DECLARATIONS**

**11a) Quality Assurance Declaration**

The *Regulated Health Professions Act, 1991* requires the College to establish and maintain a Quality Assurance Program. As defined in our General Regulation Part VI, and in the Quality Assurance Program policies and guidelines as distributed to Registrants, every Registrant shall participate in the Quality Assurance Program.

I hereby declare that I understand my obligations and have completed the mandatory requirements, including the Self-Assessment Tool, Professional Development Plan, and Prescribed Regulatory Education Program (PREP), as applicable.

Signature	Date	Witness

**11b) Registration Declaration (Must be signed, dated and witnessed.)**

I hereby certify that the statements made by me in this application are complete and correct to the best of my knowledge and belief. I understand that the College reserves the right to verify any information I provide. I understand that a false or misleading statement may disqualify me from registration or may be cause for revocation of any registration which may be granted me.

Signature	Date	Witness

**SECTION 12 - ADDITIONAL INFORMATION**

Use this space to provide any information that you did not have room for in the body of the form. Use an additional sheet if necessary.

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