



REGISTRATION RENEWAL IS DUE JUNE 1, 2009

Please allow extra time to complete this form, as several new questions have been added.

The annual registration fee is \$690.43 (\$657.55 + \$32.88 GST).

Review the Annual Registration Guide for assistance. The Guide is available on the College website at www.coto.org in the Registration section under Annual Registration.

You are encouraged to renew your certificate online at www.coto.org > Registration > Annual Registration. Select eReg Online Registration Renewal to view your online form which will contain all your data currently on file with the College. Completion of the printed form will require you to complete all data fields.

You may notice that this year's form is longer than in the past. The Ministry of Health and Long-Term Care and the College of Occupational Therapists of Ontario are working together to learn more about occupational therapists by collecting demographic, geographic, educational, and employment information. This data collection is part of HealthForceOntario, the province's health human resources strategy. Your answers will help the Ministry develop policies and programs that address supply and distribution, education, recruitment and retention for occupational therapists.

All of Ontario's 80,000 regulated allied health professionals are providing this information as part of their annual registration and renewal process. To protect your privacy, the data the College submits to the Ministry will be anonymized. You are required to provide this information under the Regulated Health Professions Act, 1991.

The reliability of the information the College receives and the quality of the decision making that follows depends on you. By completing this form accurately and thoroughly, you will help ensure that Ontarians have access to the services of occupational therapy, when and where they are needed.

Thank you.

SECTION 1 - GENERAL INFORMATION

Legal First Name	Legal Last Name	Middle name
Commonly Used FIRST Name in Practice	Previous Legal First Name (if you have changed your name since graduation)	
Commonly Used LAST Name in Practice	Previous Legal Last Name (if you have changed your name since graduation)	
Home Address (Street Name, Number, Unit/Apartment)		
City	Province/Country	
Postal Code	Preferred Mailing Address <input type="checkbox"/> Home <input type="checkbox"/> Work	
Telephone ( )	E-mail	

Languages of Service

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

1)	2)	3)
4)	5)	

**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, 2009. 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.

Last day of OT employment \_\_\_\_\_

Signature \_\_\_\_\_

Please indicate the reason for cancelling your certificate of registration:

- |  |  |
|--|--|
| <input type="checkbox"/> Leaving the country   | <input type="checkbox"/> Return to School                              |
| <input type="checkbox"/> Leaving the province (leaving Ontario for another province in Canada)   | <input type="checkbox"/> Retiring (no longer part of the labour force) |
| <input type="checkbox"/> Leave (on leave from practising as an OT; e.g. maternity leave)         | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Changing profession (leaving current profession for another profession) |  |

**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 do NOT meet any of the above currency requirements and require a review |
| <input type="checkbox"/> I completed a re-entry program within the past 18 months |  |

**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*)

- |  |   |
|--|---|
| <input type="checkbox"/> Employed in OT                          | <input type="checkbox"/> Unemployed and not seeking employment in OT              |
| <input type="checkbox"/> Employed, on leave                      | <input type="checkbox"/> Working outside of profession and seeking work in OT     |
| <input type="checkbox"/> Unemployed and seeking employment in OT | <input type="checkbox"/> Working outside of profession and not seeking work in OT |

Leave Start Date (*dd/mm/yy*)

Leave End Date (*if applicable*)

### 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 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.*)

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
	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)
- 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 number of hours worked per week
- Casual (your official status with your employer is on an as-needed basis)
- \_\_\_\_\_ Enter approximate 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
	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)
- 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 number of hours worked per week
- Casual (your official status with your employer is on an as-needed basis)
- \_\_\_\_\_ Enter approximate 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)
- 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 number of hours worked per week
- Casual (your official status with your employer is on an as-needed basis)  
\_\_\_\_\_ Enter approximate 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 - h) 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 a criminal offence 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)



**SECTION 13 PAYMENT**

**ANNUAL RENEWAL FEE**

IF PAID ON OR BEFORE JUNE 1, 2009: **\$690.43** (\$657.55 renewal fee + \$32.88 GST)

IF PAID AFTER JUNE 1, 2009: **\$795.43** (\$657.55 renewal fee + late fee \$100.00 + \$37.88 GST)

**13a) Method of Payment**

Please Note: A \$25.00 fee + GST will be charged to all cheque payments that are returned Non Sufficient Funds (NSF) or credit card payments that are processed in the College office and declined.

**PAYMENT OPTION #1**

Visa     MasterCard     American Express    *(For credit card payments, please complete the selection below.)*

Card Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Expiry Date:

--	--	--	--

Name on Card *(please print clearly)*

Total Amount Authorized

Cardholder's Signature

\$

**PAYMENT OPTION #2**

Cheque     Money Order     Telebanking    *(Please make payable to COTO and include your registration number on the cheque.)*

**13b) Submitting Your Payment**

**BY MAIL/COURIER:** College of Occupational Therapists of Ontario  
20 Bay St, Suite 900  
PO Box 78  
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