



Change of INFORMATION

CRTO Members are asked to inform the CRTO of any change to the information provided during the application or registration renewal process.

To update your information, complete all applicable sections and submit this change of information form **within 30 days** of any change to your contact, employment, education or conduct information. You may also update your information online at www.crto.on.ca.

1. PERSONAL DATA

FIRST NAME SURNAME CRTO Registration No.

NEW* FIRST NAME NEW* SURNAME

*A name change request must be submitted in writing together with a photocopy of Marriage Certificate, Change of Name Certificate or other evidence of legal name change.

2. HOME ADDRESS / CONTACT INFORMATION UPDATE

N/A – NO CHANGE

APT. NO. STREET ADDRESS

CITY PROVINCE

POSTAL CODE COUNTRY

EMAIL

PHONE NUMBER MOBILE

3. EMPLOYMENT STATUS UPDATE (applies to all practice sites)

N/A – NO CHANGE

Working in Respiratory Therapy in Ontario

Working in Respiratory Therapy outside of Ontario

Working outside of Respiratory Therapy but seeking Respiratory Therapy work

Working outside of Respiratory Therapy and not seeking Respiratory Therapy work

Not working but seeking Respiratory Therapy work

Not working and not seeking Respiratory Therapy work

Retired, please provide your Respiratory Therapy employment end date: (M/D/YY)

Leave of Absence: Medical Parental Academic Other: _____

Leave Start Date: (MM/DD/YYYY) _____ End Date: (MM/DD/YYYY) _____

OFFICE USE ONLY								RECEIVED DATE	NOTES
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4. EMPLOYMENT PRIMARY ADDITIONAL N/A – NO CHANGE

EMPLOYER / BUSINESS NAME

DEPARTMENT

PRACTICE SETTING TYPE (e.g., hospital)

ADDRESS

CITY

PROVINCE

POSTAL CODE

PHONE

EXT.

FAX

IMMEDIATE SUPERVISOR (Name and Title)

Employment Category Permanent Temporary Casual Self Employed

Status Full Time Part Time Casual

START DATE (MM/DD/YYYY):

END DATE, IF applicable (MM/DD/YYYY):

Position Type (Choose ONE only)

- | | | |
|---|---|--|
| <input type="checkbox"/> Staff RT | <input type="checkbox"/> Consultant | <input type="checkbox"/> Polysomnography RT |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Faculty (post-secondary education) | <input type="checkbox"/> Pulmonary Function RT |
| <input type="checkbox"/> Anesthesia Assistant | <input type="checkbox"/> Home Care RT | <input type="checkbox"/> Pulmonary Rehabilitation RT |
| <input type="checkbox"/> Cardiac Diagnostics RT | <input type="checkbox"/> Hyperbaric RT | <input type="checkbox"/> Quality Management Specialist |
| <input type="checkbox"/> Cardiovascular Perfusionist | <input type="checkbox"/> Infection Control Practitioner | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Case Manager/Co-ordinator | <input type="checkbox"/> Manager | <input type="checkbox"/> Sales Representative |
| <input type="checkbox"/> Charge Therapist/PPL/Senior RT | <input type="checkbox"/> Owner/Operator | <input type="checkbox"/> Transport RT |
| <input type="checkbox"/> Clinical Educator/Instructor | <input type="checkbox"/> Patient Educator/Patient Outreach | <input type="checkbox"/> Other: |

Main Area of Practice (Choose ONE only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Diagnostics | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Administration / Management | <input type="checkbox"/> Education (post-secondary education) | <input type="checkbox"/> Pulmonary Function Testing |
| <input type="checkbox"/> Anesthesia / Operating Room | <input type="checkbox"/> Emergency | <input type="checkbox"/> Quality Management |
| <input type="checkbox"/> Chronic Disease Prevention | <input type="checkbox"/> Home Care | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Chronic / Long Term Care | <input type="checkbox"/> Infection Control | <input type="checkbox"/> Research |
| <input type="checkbox"/> Comprehensive Primary Care (e.g., FHT) | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Ventilator Equipment Pool |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Patient / Client Education | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Patient Transport (i.e., Air/Land) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Polysomnography | |

Other Areas of Practice (Choose ALL that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Diagnostics | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Administration / Management | <input type="checkbox"/> Education (post-secondary education) | <input type="checkbox"/> Pulmonary Function Testing |
| <input type="checkbox"/> Anesthesia / Operating Room | <input type="checkbox"/> Emergency | <input type="checkbox"/> Quality Management |
| <input type="checkbox"/> Chronic Disease Prevention | <input type="checkbox"/> Home Care | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Chronic / Long Term Care | <input type="checkbox"/> Infection Control | <input type="checkbox"/> Research |
| <input type="checkbox"/> Comprehensive Primary Care (e.g., FHT) | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Ventilator Equipment Pool |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Patient / Client Education | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Patient Transport (i.e., Air/Land) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Polysomnography | |

Main Category of Patients/Clients (Choose ONE only)

- | | | |
|-----------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> All Ages | <input type="checkbox"/> Neonatal | <input type="checkbox"/> Seniors |
| <input type="checkbox"/> Adult | <input type="checkbox"/> Paediatric | <input type="checkbox"/> N/A |

5. EDUCATION N/A – NO CHANGE

	Field of Study	Name of Academic Institution	Province/Country	Year of graduation
<input type="checkbox"/> Diploma				
<input type="checkbox"/> Baccalaureate				
<input type="checkbox"/> Master				
<input type="checkbox"/> Doctorate				
<input type="checkbox"/> Other				

6. CERTIFICATIONS UPDATE N/A – NO CHANGE

Certificate Type	Year Completed

7. PROFESSIONAL CONDUCT N/A – NO CHANGE

I have been found guilty of (check all that apply):

- a criminal offence in Canada or in any jurisdiction outside Canada*
- an offence related to prescribing, compounding, dispensing, selling or administering drugs*
- an offence that occurred while practising health care*
- an offence in which you were impaired or intoxicated*
- any other offence relevant to your suitability to practise the profession*
- I have been disciplined, suspended, required to resign, terminated or subjected to similar action in respect to employment or a contract of service*
- I have been found guilty of professional negligence or malpractice*
- I have been the subject of a professional misconduct, incompetence, incapacity or other similar proceeding or investigation by any professional licensing or registration body other than the CRTO*
- Other events, circumstances, or conditions relevant to my competence, conduct or physical or mental capacity that might be relevant to my ability or suitability to function as a Respiratory Therapist*

*provide full particulars on a separate sheet of paper and attach to this form.



SIGNATURE: _____

DATE: _____

MAIL: CRTO
 2103-180 DUNDAS ST. W.
 TORONTO, ON M5G 1Z8

FAX: (416) 591-7890
EMAIL: questions@crto.on.ca

QUESTIONS

If you have any questions contact us at: Telephone 416-591-7800 or toll free 1-800-261-0528; Email walsh@crto.on.ca