



College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103
Toronto, Ontario M5G 1Z8
www.crto.on.ca

Document Request Form

RESPIRATORY THERAPY PROGRAM REVIEW

SECTION 1 – completed by the applicant

First Name:

Middle Name(s):

Surname:

Previous Name(s) (if applicable):

Student ID Number:

I agree to allow my Respiratory Therapy program to give the information/documentation required by the College of Respiratory Therapists of Ontario for the purpose of my Respiratory Therapy education evaluation.

SIGNATURE: _____ **DATE:** _____

SECTION 2 – completed by an authorized official

Note to Authorized Official: The above-named person applied to the College of Respiratory Therapists of Ontario (CRTO) for a Respiratory Therapy program review. To help us in the review process, please complete this form and provide the required information / documentation.

We ask that the form be completed by the Program Director or the Registrar. Once completed, please send this form and all documentation directly to the CRTO (not to the applicant).

Name of Official Completing Form (Please type or PRINT):

Title:

Name of Institution:

Address of the Institution:

Telephone:

Fax:

Email:

SIGNATURE: _____ **DATE:** _____

Name of degree/diploma:

Language of Instruction:

Student's admission date:

Student's completion date (including clinical practice):

Length of the program:

Semesters of study:

Years:

Number of credits:

How many weeks in one semester?

How many hours in one credit?

Program accreditation status:

Name of the accreditation body:

Did the program cover the following topics during the didactic semesters:

Anatomy/physiology	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Pathophysiology	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Pharmacology (respiratory, cardiac, renal, anesthesia, pain)	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Airway Management (neonatal, paediatric, adult)	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Mechanical Ventilation	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Oxygen and specialty gas administration	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Anesthesia care	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Pulmonary Function Testing	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Neonatal/paediatric care	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Other (provide details)		Hrs:	

Total Hours:

Did the clinical rotations cover the following clinical sites/practice areas:

Adult critical care unit	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Paediatric/neonatal critical care unit	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Operating Room	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Emergency/Casualty Dept.	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
General Wards	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Pulmonary Function Testing Laboratory	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Cardiac diagnostics (i.e. holter, 12 Lead ECGs)	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Home care (home oxygen therapy and related equipment)	<input type="checkbox"/> Yes	Hrs:	<input type="checkbox"/> No
Other (provide details)		Hrs:	

Total Hours:

