



PRE-REGISTRATION FORM

For applicants educated outside of Canada

For information on how to complete this form, please refer to the PRE -REGISTRATION GUIDE

1. PERSONAL DATA

First Name

Middle Name(s)

Surname

Previous Name(s) (if applicable)

Date of Birth (mm/dd/yyyy)

Gender Male Female

Have you previously applied for registration? Yes No

2. HOME ADDRESS / CONTACT INFORMATION

Apt. No.

Street Address

City

Province

Postal Code

Country

Phone Number

Mobile

E-Mail

3. RESIDENCY STATUS

- I am a Canadian Citizen
- I am a Permanent Resident/Landed Immigrant of Canada
- Other (e.g. student visa, work permit) Please provide details:

4. LANGUAGE PROFICIENCY

Is your first language English or French? Yes No

If the answer is no, please provide proof of language proficiency (see guide)

5. PRIMARY RT (OR OTHER) EDUCATION * see Guide for required documentation

Name of Program of Study: _____

Credential: Diploma Baccalaureate Other: _____

Name of Educational Facility: _____

Country: _____

Year of Graduation: _____

External credential review report: WES Canada Other: _____

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

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

Total Hours:

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

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

Total Hours:

6. ADDITIONAL EDUCATION

	Field of Study	Name of Academic Institution	Country	Year(s)
<input type="checkbox"/> Certificate				
<input type="checkbox"/> Diploma				
<input type="checkbox"/> Baccalaureate				
<input type="checkbox"/> Master				
<input type="checkbox"/> Doctorate				
<input type="checkbox"/> Other				

7. PROFESSIONAL REGISTRATION * see Guide for required documentation

Are you or have you ever been registered/licensed to practice as Respiratory Therapist, or other health care profession(s) in other country?

Yes No

If yes, provide the information requested below and complete the Registration Verification Form to support your status or registration with a regulatory / licensing organization.

Regulatory/Licensing Body	Reg./License No.	Province / State / Country	Expiry Date

8. EMPLOYMENT PROFILE

Employment History

Have you ever practiced as a Respiratory Therapist or other health care practitioner in any jurisdiction at any time?

No If no, please skip to section 9

Yes If yes, please List the name and address information of all your employers, starting with the most recent. Please include start and finish dates and verification of employment.

Start date	End date	Position Held
Employer Name		
Employer address		Province / State Country
Telephone number		
Start date	End date	Position Held
Employer Name:		
Employer address		Province / State Country
Telephone number		
Start date	End date	Position Held
Employer Name		
Employer address		Province / State Country
Telephone number		
Start date	End date:	Position Held
Employer Name		
Employer address		Province / State Country
Telephone number		

If needed, please continue on a separate sheet of paper.

9. DECLARATION AND AUTHORIZATION

- I **declare**/hereby certify that the statements made by me in this application are complete and correct to the best of my knowledge and belief.
- I hereby **authorize** the sources referred to on this form to release to the College of Respiratory Therapists of Ontario all information about me in the possession of the source for the purpose of College registration.
- I consent to the College providing this information to a Respiratory Therapy program for the purpose my application to that program.



SIGNATURE

DATE

10. SUBMITTING YOUR FORM

CRTC Mailing Address	College of Respiratory Therapists of Ontario 180 Dundas Street West, Suite 2103; Toronto, ON M5G 1Z8
CRTC Contact Information	tel: 416-591-7800 or toll free 1-800-261-0528 fax: 416-591-7890 e-mail: walsh@crto.on.ca www.crto.on.ca



PRE REGISTRATION CHECKLIST

Please refer to the checklists below for a list of the documentation required as part of your CRTO application. For information on how to complete the application form, please refer to the **Registration Application Guide**.

- C Pre-registration form**
Completed, signed and dated
- C Proof of Canadian citizenship, permanent residency status or a valid work permit**
E.g. photocopy of birth certificate, residency card
- C Proof of Language Proficiency (if applicable)**
If your first language is neither English nor French and your Respiratory Therapy (or related field) training was not in English or French
- C World Education Services Evaluation**
Ensure that your transcript evaluation has been sent directly to the College from WES; applies to applicants educated outside of Canada
- C Registration Verification Form (if applicable)**
If you have been registered as a Respiratory Therapist in another jurisdiction, or in any other health profession.
- C Employment Verification Form (if applicable)**

Once completed, mail your application and the supporting documentation to:

College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103; Toronto, ON M5G 1Z8

If you have any questions about the application process, please contact the CRTO by:

telephone: 416-591-7800 or toll free 1-800-261-0528; e-mail: walsh@crto.on.ca
