



2012 REGISTRATION RENEWAL

Please complete the entire form and submit with payment by March 1, 2012.

For assistance completing the form please refer to the Registration Renewal Guide posted on the CRTO website at www.crto.on.ca. You may also complete your registration renewal online. This option is available to all Members whose valid email addresses are on file with the College and who do not wish to change their registration status (e.g. from Inactive to Active). To access the online registration renewal go to the "Member Login" section on the CRTO website www.crto.on.ca.

Please note renewal forms are not accepted by fax.

If you do not plan to practice Respiratory Therapy in Ontario you may choose to resign your membership. To do so please complete and submit the **Resignation Form** posted on our website. If you fail to renew or resign your membership with the College by March 1, 2012 your membership may be suspended for non-payment of fees.

REGISTRATION CLASS

Please indicate your class of registration for the 2012 registration year:

General **Limited** **Graduate** **Inactive***

* Only Members registered in the General or Limited Class of registration may change their registration to Inactive

PERSONAL INFORMATION

CRTO Registration Number

First Name

Last Name (as currently on file)

Change of Name* attach a copy of a marriage certificate, change of name certificate or certificate of divorce

Home Address

City

Province

Postal Code

Country

Home Phone

Mobile Phone

Preferred E-mail

LANGUAGE FLUENCY

Please list all languages in which you are currently capable of providing respiratory therapy services:

English **French** **Other** (please specify):

REGISTRATION IN OTHER JURISDICTIONS

Are you currently registered to practice as a Respiratory Therapist in any other jurisdiction? Yes* No

Are you currently registered to practice another health profession? Yes* No

*If your answer is YES to either of the above, please provide the following:

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

CONDUCT * If your answer is "YES" to any of the questions below please provide full particulars on a separate sheet of paper and attach to this form.

- Since your last application or last renewal have you been found guilty of? (You must report findings even if they resulted in a discharge or pardon.)
 - a criminal offence in Canada or in any jurisdiction outside Canada; Yes* No
 - an offence related to prescribing, compounding, dispensing, selling or administering drugs; Yes* No
 - an offence that occurred while practicing health care; Yes* No
 - an offence in which you were impaired or intoxicated; or Yes* No
 - any other offence relevant to your suitability to practice the profession. Yes* No
- Since your last application or renewal have you been found guilty of professional negligence or malpractice? Yes* No
- Since your last application or last renewal have you been disciplined, suspended, required to resign, terminated or subjected to similar action in respect to employment or a contract of service? Yes* No
- Since your last application or last renewal have you been the subject of any professional misconduct, incompetence, incapacity or other similar proceeding or investigation by any professional licensing or registration body other than the CRTO? Yes* No
- Is there any event, circumstance, condition or matter not disclosed in your replies to the preceding questions relevant to your competence, conduct or physical or mental capacity that might be relevant to your ability or suitability to function as a Respiratory Therapist? Yes* No

EDUCATION Please provide information regarding your post-secondary education in Respiratory Therapy and other disciplines.

	Field of Study	Institution	Province / Country	Year Completed / In Progress
<input type="checkbox"/> Diploma				
<input type="checkbox"/> Baccalaureate				
<input type="checkbox"/> Masters				
<input type="checkbox"/> Doctorate				
<input type="checkbox"/> Other (specify)				

CERTIFICATIONS If you have any special certifications, such as ACLS, PALS, NRP, please provide the following information:

Certificate Type	Year Completed

PRIMARY EMPLOYMENT

Employer / Business Name

Department

Address

City

Province

Postal Code

Phone

Ext.

Fax

Immediate Supervisor (Name and Title)

Employment Category ff7\ccgY'cb'mCB9E
 Permanent
 Temporary
 Casual
 Self Employed

Status ff7\ccgY'cb'mCB9E
 Full Time
 Part Time
 Casual

Start Date (MM/DD/YYYY):

End Date, if applicable (MM/DD/YYYY):

Practice Setting (Choose only ONE)

- | | | |
|---------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Ambulance Service | <input type="checkbox"/> Group Health Centre (Sault St. Marie) | <input type="checkbox"/> PFT Lab |
| <input type="checkbox"/> Assisted Living Residence | <input type="checkbox"/> Group Practice Office | <input type="checkbox"/> Public Health Unit |
| <input type="checkbox"/> Association / Government / Reg. Body | <input type="checkbox"/> Health Related Business/Industry | <input type="checkbox"/> Rehabilitation Centre |
| <input type="checkbox"/> Children Treatment Centre (CTC) | <input type="checkbox"/> Home Care Company | <input type="checkbox"/> Residential / Long-Term Facility |
| <input type="checkbox"/> Community Care Access Centre | <input type="checkbox"/> Hospital | <input type="checkbox"/> Solo Practice Office |
| <input type="checkbox"/> Community Health Centre | <input type="checkbox"/> Laboratory Facility | <input type="checkbox"/> Urgent Care Centre |
| <input type="checkbox"/> Educational Institution | <input type="checkbox"/> Medical/Dental Clinic | <input type="checkbox"/> Walk-In After Hours Clinic |
| <input type="checkbox"/> Family Health Team | <input type="checkbox"/> Nurse Practitioner-Led Clinic | <input type="checkbox"/> Other: |

Position Type (Choose only ONE)

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

Main Area of Practice (Choose only ONE)

- | | | |
|-----------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------|
| <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 | <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 | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Patient/Client Education | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Patient Transport | |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Polysomnography | |

Main Category of Patients/Clients (Choose only ONE)

- | | | |
|-----------------------------------|-------------------------------------|----------------------------------|
| <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 |

ADDITIONAL EMPLOYMENT

Employer / Business Name

Department

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):

Practice Setting (Choose only ONE)

- | | | |
|---------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Ambulance Service | <input type="checkbox"/> Group Health Centre (Sault St. Marie) | <input type="checkbox"/> PFT Lab |
| <input type="checkbox"/> Assisted Living Residence | <input type="checkbox"/> Group Practice Office Other | <input type="checkbox"/> Public Health Unit |
| <input type="checkbox"/> Association / Government / Reg. Body | <input type="checkbox"/> Health Related Business/Industry | <input type="checkbox"/> Rehabilitation Centre |
| <input type="checkbox"/> Children Treatment Centre (CTC) | <input type="checkbox"/> Home Care Company | <input type="checkbox"/> Residential / Long-Term Facility |
| <input type="checkbox"/> Community Care Access Centre | <input type="checkbox"/> Hospital | <input type="checkbox"/> Solo Practice Office |
| <input type="checkbox"/> Community Health Centre | <input type="checkbox"/> Laboratory Facility | <input type="checkbox"/> Urgent Care Centre |
| <input type="checkbox"/> Educational Institution | <input type="checkbox"/> Nurse Practitioner-Led Clinic | <input type="checkbox"/> Walk-In After Hours Clinic |
| <input type="checkbox"/> Family Health Team | <input type="checkbox"/> Medical/Dental Clinic | <input type="checkbox"/> Other: |

Position Type (Choose only ONE)

- | | | |
|-------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Staff RT | <input type="checkbox"/> Home Care RT | <input type="checkbox"/> Pulmonary Function RT |
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| <input type="checkbox"/> Cardiovascular Perfusionist | <input type="checkbox"/> Manager | <input type="checkbox"/> Sales Representative |
| <input type="checkbox"/> Charge Therapist / Senior RT | <input type="checkbox"/> Owner / Operator | <input type="checkbox"/> Transport RT |
| <input type="checkbox"/> Clinical Educator | <input type="checkbox"/> Patient Educator/Patient Outreach | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Polysomnography RT | |
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Main Area of Practice (Choose only ONE)

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| <input type="checkbox"/> Administration/Management | <input type="checkbox"/> Education (post-secondary education) | <input type="checkbox"/> Pulmonary Function Testing |
| <input type="checkbox"/> Anesthesia | <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 | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Patient/Client Education | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Patient Transport | |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Polysomnography | |

Main Category of Patients/Clients (Choose only ONE)

- | | | |
|-----------------------------------|-------------------------------------|----------------------------------|
| <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 |

For additional RT related employment, please use a separate sheet of paper and attach to this form.

RT ACTIVITIES

Do you perform any of the following activities? Please consider all RT employment settings. Choose all that apply.

<input type="checkbox"/> Administration of oral medications (e.g., oral steroids)	Diagnostics
<input type="checkbox"/> Arterial blood gas puncture	<input type="checkbox"/> Bronchoprovocation (histamine/methacholine)
<input type="checkbox"/> Aspiration from a cannula/line	<input type="checkbox"/> Cardiac stress testing
<input type="checkbox"/> Bronchoscopy (performing)	<input type="checkbox"/> Echocardiography
<input type="checkbox"/> Cardiovascular perfusion/ECMO	<input type="checkbox"/> Holter monitoring
<input type="checkbox"/> Cardioversion (performing)	<input type="checkbox"/> Neurodiagnosis (includes EMG, EEG)
<input type="checkbox"/> Conscious sedation (assisting)	<input type="checkbox"/> Polysomnography
<input type="checkbox"/> Conscious sedation (performing)	<input type="checkbox"/> Pulmonary function
<input type="checkbox"/> Defibrillation (performing)	Inhalation
<input type="checkbox"/> Dispensing medications (e.g., MDI, NRT)	<input type="checkbox"/> Anaesthetic agents or gases
<input type="checkbox"/> Interosseous cannulation	<input type="checkbox"/> High frequency oscillation ventilation (adult)
<input type="checkbox"/> Intubation adult	<input type="checkbox"/> High frequency oscillation ventilation (paediatric/neonatal)
<input type="checkbox"/> Intubation neonatal	<input type="checkbox"/> Hyperbarics
<input type="checkbox"/> Intubation paediatric	<input type="checkbox"/> Mechanical ventilation (invasive and non-invasive)
<input type="checkbox"/> LMA insertion	<input type="checkbox"/> Nitric oxide
<input type="checkbox"/> Needle cricothyrotomy (performing)	Injection
<input type="checkbox"/> Patient/client education	<input type="checkbox"/> Injection - artificial opening
<input type="checkbox"/> Patient transport air	<input type="checkbox"/> Injection direct
<input type="checkbox"/> Patient transport land	<input type="checkbox"/> Injection via epidural
<input type="checkbox"/> Percutaneous tracheostomy (assisting)	<input type="checkbox"/> Injection via line or bag
<input type="checkbox"/> Smoking cessation/nicotine replacement therapy	Other:
<input type="checkbox"/> Suturing an indwelling cannula/line	<input type="checkbox"/>
<input type="checkbox"/> Tracheostomy tube change	<input type="checkbox"/>
<input type="checkbox"/> Venipuncture	<input type="checkbox"/>

Advanced Prescribed Procedures Below the Dermis

NOTE: You may not perform an advanced prescribed procedure unless you have, within two years before the procedure is performed, successfully completed a certification or recertification program approved by the College.

<input type="checkbox"/> Arterial cannula/line insertion
<input type="checkbox"/> Chest needle (insertion, aspiration, reposition, removal)
<input type="checkbox"/> Chest tube (insertion, aspiration, reposition, removal)
<input type="checkbox"/> Umbilical cannula / line insertion
<input type="checkbox"/> Venous cannula / line insertion

DELEGATION

**Are you accepting delegation of any controlled act(s) from a regulated health care professional?
If yes, indicate below.**

Applying a form of energy:

- Cardiac pacemaker therapy
- Defibrillation
- Cardioversion
- Electromyography
- Nerve conduction studies
- Sound waves for diagnostic ultrasound
- Transcutaneous cardiac pacing
- Allergy challenge testing**
- Performing a procedure on tissue below the surface of a mucous membrane**

Putting an instrument, hand or finger:

- Beyond the external ear canal
- Beyond the labia majora
- Beyond anal verge
- Into an artificial opening into the body
- Communicating a diagnosis**
- Dispensing drugs**
- Reinsert Trach Tube < 24 hours**
- Other:**

Are you delegating any RT authorized acts?

If yes, please specify both the act(s) and to which health care provider(s) it was delegated.

Authorized Acts:

- Performing a prescribed procedure below the dermis
- Intubation beyond the point in the nasal passages where they normally narrow or beyond the larynx
- Suctioning beyond the point in the nasal passages where they normally narrow or beyond the larynx
- Administering a substance by injection or inhalation

Delegated to (e.g. PSW):**DECLARATION**

- I certify** that I am covered by personal/employer **professional liability insurance** in the amounts and coverage set out in the [CRTO Professional Liability Insurance Policy](#).

***If you do not have a professional liability insurance coverage, please complete the following:**

- I am requesting an exemption from the Professional Liability Insurance requirement on the grounds that I am not currently engaged in the practice of Respiratory Therapy (either Inactive or non-practicing), and
- I have read and understood the Professional Liability Insurance policy of the CRTO and will obtain insurance before practicing.

- I **declare** that I am participating in the CRTO **Quality Assurance Program** by maintaining my PORTfolio on an ongoing basis. It is required that all CRTO Members maintain their PORTfolios, as this condition of registration is set out in regulation.

***If you are not participating in the CRTO Quality Assurance Program please provide a full explanation on a separate sheet of paper and attach to this renewal form.**

- I agree** to notify the College, in writing, within 30 days, of any change(s) to the information contained on this form including personal data, employment status, and professional registration and conduct information.
- I declare/hereby certify** that the statements made by me on this form are complete and correct to the best of my knowledge and belief.
- I understand** that making a false or misleading statement or representation to the College may be considered professional misconduct under Ontario Regulation 753/93.



Signature: _____ **Date:** _____

See Page 8 for payment options

PAYMENT

MEMBERSHIP FEES (Choose all that apply)	OTHER FEES (Choose all that apply)
<input type="checkbox"/> \$500.00 General	<input type="checkbox"/> \$100.00 Late (General, Limited, Graduate)
<input type="checkbox"/> \$500.00 Limited	<input type="checkbox"/> \$25.00 Late (Inactive)
<input type="checkbox"/> \$500.00 Graduate	<input type="checkbox"/> \$35.00 NSF Charge
<input type="checkbox"/> \$50.00 Inactive*	<input type="checkbox"/> \$250.00 Reinstatement Fee

* Only Members registered in the General or Limited Class of registration may change their registration to Inactive

METHOD OF PAYMENT

Personal Cheque / Money Order (made payable to the CRTO)

Employer Cheque (enclosed)

Employer Cheque (to be submitted directly by the employer)

CSRT Payment (to be submitted directly by the CSRT) If you are paying your CRTO membership fee through the CSRT, please make sure to submit your payment to the CSRT before **February 17, 2012**.

Online / Tele Banking Name of Financial Institution: _____
 Transaction Date: _____ Ref No. _____

CREDIT CARD

VISA

MASTERCARD

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Credit Card Number

--	--	--	--

Expiry Date

\$ **Total Amount Authorized** _____

_____ **Cardholder's Signature** _____ **Cardholder's Name**

<p> MAIL YOUR FORM TO:</p> <p>CRTO 2103-180 DUNDAS ST. W. TORONTO, ON M5G 1Z8</p> <p>Renewal forms are not accepted by fax.</p>	<p>RENEWAL CHECKLIST:</p> <p><input type="checkbox"/> You completed all sections of the renewal form</p> <p><input type="checkbox"/> You signed and dated the renewal form</p> <p><input type="checkbox"/> You enclosed the applicable payment / payment information</p>
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For more information on the renewal process see the **2012 Registration Renewal Guide** www.crto.on.ca or contact us at: **Telephone:** 416-591-7800 or toll free 1-800-261-0528; **Email** walsh@crto.on.ca

COMMENTS:

OFFICE USE ONLY	DATE FORM RECEIVED	PAYMENT DATE	DATA ENTRY DATE
NOTES:			STAFF INITIAL