College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

Application for FUNDING

FORM B TO BE COMPLETED BY THE APPLICANT'S THERAPIST/COUNSELLOR

The CRTO maintains a program to provide funding for therapy and counselling to patients who allege that they were sexually abused by a Member of the CRTO. For more information, please refer to the Funding for Therapy Fact Sheet. The Patient Relations Committee (PRC) oversees the funding for therapy and counselling program.

Form B can be submitted with **Form A** or after eligibility is determined by the Patient Relations Committee of the College of Respiratory Therapists of Ontario (CRTO).

1. THERAPIST/COUNSELLOR INFORMATION

FIRST NAME	LAST NAME
WORK ADDRESS	
CITY	PROVINCE
POSTAL CODE	COUNTRY
PHONE NUMBER	EMAIL

Are you a member of a regulated health profession?

☐ YES Please provide the name of the regulatory body:

Your registration number:

☐ NO Please provide information (e.g., attach a copy of your resume) about your training or experience related to providing therapy or counselling to survivors of sexual abuse.

2. PATIENT/CLIENT INFORMATION

FIRST NAME	LAST NAME
PHONE NUMBER	EMAIL

3. DECLARATION

1. I confirm that I do not have any family relationship or any other potential conflict of interest with the applicant (patient/client).
2. I have not at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature.
3. I understand that the funding should be used only to pay for therapy and counselling and should not be applied directly or indirectly for any other purpose.
4. I understand that other sources of funding (e.g., OHIP or private insurance) must be used first and that there can be no duplicate payment for the same service.

5. I understand that the CRTO may verify the service dates with the patient.
6. I undertake to keep confidential all information obtained through the application for funding process, including if funding is granted, the fact that funding has been granted, and to refrain from using that information for any other purpose.
7. I declare/hereby certify that the statements made on this form are complete and correct to the best of my knowledge and belief.

4. SIGNATURE

THERAPIST/COUNSELLOR SIGNATURE: DATE:

Completed application should be emailed to officeofregistrar@crto.on.ca or mailed to:

Patient Relations Committee
College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103
Toronto, Ontario M5G 1Z8

Questions? If you have further questions, please contact the CRTO office at 1-800-261-0528 or 416-591-7800 or officeofregistrar@crto.on.ca.