

EMPLOYMENT Verification Form

SECTION 1			
	the applicant and forwarded to the place of employment in the jurisdiction(s) in whitst (or in a related field) over the past five years .	ch you have b	peen
l,	hereby authorize EMPLOYER NAME		
PRINT NAME	EMPLOYER NAME		
to provide the information requested order to process my application for	d below and any additional information requested by the College of Respiratory The registration.	erapists of On	itario in
APPLICANT'S SIGNATURE	DATE		
SECTION 2			
within 15 days of receipt.	the employer (preferably by the applicant's immediate supervisor) and forwarded d	irectly to the	CRTO
This is to certify thatAPPLICANT	T'S NAME		
is / was employed byNAME OF E	EMPLOYER		
asPOSITION TITLE			
	LAST DATE OF EMPLOYMENT:	(IF APPLICA	(BLE)
	iplined, suspended, required to resign, terminated or subjected to similar nent or a contract of service?	☐ Yes*	□ No
2. Are you aware of any other information (e.g., court or tribunal findings, complaints) about the applicant's competence, conduct, or physical/mental capacity that could reasonably affect the applicant's ability to function as a Respiratory Therapist?			☐ No
*If the answer is "Yes", please provide a	additional information, including a description of the matter, relevant findings and any resulting	ng orders/penal	lties.
NAME OF AUTHORIZED FACILITY REP	PRESENTATIVE TITLE		
PHONE NUMBER	EMAIL		
- OLOMATURE			
SIGNATURE	DATE		

THE FORM MUST BE SUBMITTED TO THE CRTO OFFICE BY THE EMPLOYER

MAIL: CRTO, 180 Dundas St. W. Ste. 2103 Toronto, ON M5G 1Z8, Canada FAX: 416-591-7890 QUESTIONS: t: 416-591-7800 or toll free 1-800-261-0528, email: ng@crto.on.ca web www.crto.on.ca