



REGISTRATION Verification Form

Applicants for registration who hold (or have held) a license or registration to practise respiratory therapy outside of Ontario or in another profession must submit the Registration Verification Form. The form must be submitted directly from the regulatory/licensing body to the College of Respiratory Therapists of Ontario (CRO).

Note: If you are registered as a Respiratory Therapist in another regulated Canadian province, please use the [NARTRB Statement of Professional Standing Form](#).

SECTION 1: CONSENT TO RELEASE INFORMATION

This section is to be filled out by the APPLICANT. Once complete please forward it to the regulatory/licensing body with which you are or have been registered.

APPLICANT INFORMATION

FIRST NAME

LAST NAME

REGISTRATION NUMBER

PHONE NUMBER

EMAIL

CONSENT TO RELEASE INFORMATION

I hereby consent to and authorize

(NAME OF CURRENT/PREVIOUS REGULATORY/LICENSING BODY)

to provide the information requested in **Section 2** and any additional information requested by the CRO in order to process my application for registration.

APPLICANT'S SIGNATURE

DATE (MM/DD/YYYY)



SECTION 2: REGISTRATION VERIFICATION

This section will be completed by the REGULATORY/LICENSING BODY with which you are or have been registered. Upon completion, it will be sent directly to the CRTO.

I, _____
PRINT (NAME OF REGISTRAR / SECRETARY or DESIGNATE)

acting on behalf of: _____
PRINT (REGULATORY/LICENSING BODY)

certify that the following statements and any additional information provided are true and accurate relating to the professional standing and registration history for:

APPLICANT'S NAME

REGISTRATION NUMBER

DATE REGISTRATION HELD:

FROM DD/MM/YY

TO DD/MM/YY

1. Does the applicant currently have/previously had terms, restrictions, conditions, or limitations on their certificate of registration/license?

YES (If YES, please provide details below).

NO

2. Does the applicant currently have/previously had their certificate of registration/license suspended or revoked?

YES (If YES, please provide details below)

NO

3. Is the applicant currently or have they previously been the subject of a formal complaint, report, investigation, discipline, and/or fitness to practice/capacity inquiry?

YES (If YES, please provide details below)

NO

N/A



4. To your knowledge, has the applicant ever been charged with, or have they ever been found guilty of an offence in any jurisdiction or country regardless of the penalty imposed (e.g., a criminal offence or an offence related to the practice of a profession)?

YES (If YES, please provide details below)

NO

5. Does the applicant have any outstanding or other unfulfilled obligations to the regulatory/licensing body (e.g., fees, fines, costs, quality assurance program/continuing competence or currency requirements)?

YES (If YES, please provide details below)

NO

6. To your knowledge, is the applicant currently or have they previously been registered/licensed to practice with any other regulatory/licensing body?

YES (If YES, please provide details below)

NO

7. Are you aware of any other event, circumstance, condition, or matter not disclosed above that you believe may be relevant to the applicant's competence, conduct, professionalism or physical/mental capacity that might impede their ability to function safely and ethically as a Respiratory Therapist?

YES (If YES, please provide details below)

NO

NAME OF REGISTRAR / SECRETARY OR DESIGNATE NAME (please PRINT)

REGISTRAR OR DESIGNATE SIGNATURE

DATE (MM/DD/YYYY)

THE FORM MUST BE SUBMITTED TO THE CRTO BY THE REGULATORY/LICENSING BODY

EMAIL: registrationservices@crto.on.ca

FAX: 416-591-7890

MAIL: CRTO, 90 Adelaide St. W. Ste. 300 Toronto, ON M5H 3V9, Canada QUESTIONS:

t: 416-591-7800 or toll free 1-800-261-0528

web: www.crto.on.ca