REGISTRATION Verification Form

SECTION 1
This section must be completed by the applicant and forwarded to the regulatory body / professional association in the jurisdiction(s) in which you have been registered as a Respiratory Therapist or in any other profession.

I, ____________________________________________ hereby authorize ____________________________________________ to provide the information requested below and any additional information requested by the College of Respiratory Therapists of Ontario in order to process my application for registration.

PRINT NAME _____________________________________________________________________________________
NAME OF REGISTRATION/LICENSING BOARD _____________________________________________________________________________________

APPLICANT'S SIGNATURE _____________________________________________________________________________________
DATE _____________________________________________________________________________________
APPLICANT'S PHONE NO. _____________________________________________________________________________________
APPLICANT'S REGISTRATION NO. _____________________________________________________________________________________

SECTION 2
This section must be completed by the regulatory body / professional association and forwarded directly to the CRTO.

I, ____________________________________________ the Registrar/Secretary acting on behalf of the NAME OF REGISTRAR / SECRETARY ____________________________________________
NAME OF THE ORGANIZATION ____________________________________________
certify that the following are true statements relating to the registration record for:

APPLICANT'S NAME _____________________________________________________________________________________
REGISTRATION NO. _____________________________________________________________________________________

Date Registration held: FROM ____________ TO __________________

1. Does the applicant have any terms conditions or limitations placed on his/her registration/license to practice? □ Yes* □ No

2. Is the applicant or has the applicant ever been the subject of professional misconduct, incompetence or incapacity proceedings? □ Yes* □ No

3. To your knowledge, has the applicant ever been found guilty of a criminal offence or an offence under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada)? □ Yes* □ No

4. Are you aware of any event, circumstance, condition or matter not disclosed above, relevant to the applicant's competence, conduct, or physical/mental capacity that may impede to the applicant's ability to function as a Respiratory Therapist? □ Yes* □ No

*If the answer is "Yes", please provide additional information, including a description of the matter, relevant findings and any resulting orders/penalties.

SIGNATURE _____________________________________________________________________________________
DATE _____________________________________________________________________________________

THE FORM MUST BE SUBMITTED TO THE CRTO OFFICE BY THE REGULATORY BODY / PROFESSIONAL ASSOCIATION
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: walsh@crto.on.ca web www.crto.on.ca