College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

Change of INFORMATION

CRTO Members are asked to inform the CRTO of any change to the information provided during the application or registration renewal process.

To update your information, complete all applicable sections and submit this change of information form **within 30 days** of any change to your contact, employment, education or conduct information. You may also update your information online at www.crto.on.ca .

1. PERSONAL DATA

FIRST NAME	SURNAME	CRTO Registration No.
NEW* FIRST NAME	NEW* SURNAME	

*A name change request must be submitted in writing together with a photocopy of Marriage Certificate, Change of Name Certificate or other evidence of legal name change.

2. HOME ADDRESS / CONTACT INFORMATION UPDATE ☐ N/A – NO CHANGE

APT. NO.	STREET ADDRESS
CITY	PROVINCE
POSTAL CODE	COUNTRY
EMAIL	
PHONE NUMBER	MOBILE

3. EMPLOYMENT STATUS UPDATE (applies to all practice sites) ☐ N/A – NO CHANGE

☐ Working in Respiratory Therapy in Ontario

☐ Working in Respiratory Therapy outside of Ontario

☐ Working outside of Respiratory Therapy but seeking Respiratory Therapy work

☐ Working outside of Respiratory Therapy and not seeking Respiratory Therapy work

☐ Not working but seeking Respiratory Therapy work

☐ Not working and not seeking Respiratory Therapy work

☐ Retired, please provide your Respiratory Therapy employment end date: (M/D/YY)

☐ Leave of Absence: ☐ Medical ☐ Parental ☐ Academic ☐ Other: ____________

Leave Start Date: (MM/DD/YYYY) ____________ End Date: (MM/DD/YYYY) ____________

OFFICE USE ONLY							RECEIVED DATE	NOTES

4. EMPLOYMENT ☐ PRIMARY ☐ ADDITIONAL ☐ N/A – NO CHANGE

EMPLOYER / BUSINESS NAME

DEPARTMENT | PRACTICE SETTING TYPE (e.g., hospital)

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): ____

Position Type (Choose ONE only)

☐ Staff RT	☐ Consultant	☐ Polysomnography RT
☐ Administrator	☐ Faculty (post-secondary education)	☐ Pulmonary Function RT
☐ Anesthesia Assistant	☐ Home Care RT	☐ Pulmonary Rehabilitation RT
☐ Cardiac Diagnostics RT	☐ Hyperbaric RT	☐ Quality Management Specialist
☐ Cardiovascular Perfusionist	☐ Infection Control Practitioner	☐ Researcher
☐ Case Manager/Co-ordinator	☐ Manager	☐ Sales Representative
☐ Charge Therapist/PPL/Senior RT	☐ Owner/Operator	☐ Transport RT
☐ Clinical Educator/Instructor	☐ Patient Educator/Patient Outreach	☐ Other:

Main Area of Practice (Choose ONE only)

☐ Acute Care	☐ Diagnostics	☐ Public Health
☐ Administration / Management	☐ Education (post-secondary education)	☐ Pulmonary Function Testing
☐ Anesthesia / Operating Room	☐ Emergency	☐ Quality Management
☐ Chronic Disease Prevention	☐ Home Care	☐ Rehabilitation
☐ Chronic / Long Term Care	☐ Infection Control	☐ Research
☐ Comprehensive Primary Care (e.g., FHT)	☐ Palliative Care	☐ Ventilator Equipment Pool
☐ Consultation	☐ Patient / Client Education	☐ Sales
☐ Continuing Care	☐ Patient Transport (i.e., Air/Land)	☐ Other:
☐ Critical Care	☐ Polysomnography	

Other Areas of Practice (Choose ALL that apply)

☐ Acute Care	☐ Diagnostics	☐ Public Health
☐ Administration / Management	☐ Education (post-secondary education)	☐ Pulmonary Function Testing
☐ Anesthesia / Operating Room	☐ Emergency	☐ Quality Management
☐ Chronic Disease Prevention	☐ Home Care	☐ Rehabilitation
☐ Chronic / Long Term Care	☐ Infection Control	☐ Research
☐ Comprehensive Primary Care (e.g., FHT)	☐ Palliative Care	☐ Ventilator Equipment Pool
☐ Consultation	☐ Patient / Client Education	☐ Sales
☐ Continuing Care	☐ Patient Transport (i.e., Air/Land)	☐ Other:
☐ Critical Care	☐ Polysomnography	

Main Category of Patients/Clients (Choose ONE only)

☐ All Ages	☐ Neonatal	☐ Seniors
☐ Adult	☐ Paediatric	☐ N/A

5. EDUCATION ☐ N/A – NO CHANGE

	Field of Study	Name of Academic Institution	Province/Country	Year of graduation
☐ Diploma				
☐ Baccalaureate				
☐ Master				
☐ Doctorate				
☐ Other				

6. CERTIFICATIONS UPDATE ☐ N/A – NO CHANGE

Certificate Type	Year Completed

7. PROFESSIONAL CONDUCT ☐ N/A – NO CHANGE

I have been found guilty of (check all that apply):

- ☐ a criminal offence in Canada or in any jurisdiction outside Canada*
- ☐ an offence related to prescribing, compounding, dispensing, selling or administering drugs*
- ☐ an offence that occurred while practising health care*
- ☐ an offence in which you were impaired or intoxicated*
- ☐ any other offence relevant to your suitability to practise the profession*

☐ I have been disciplined, suspended, required to resign, terminated or subjected to similar action in respect to employment or a contract of service*

☐ I have been found guilty of professional negligence or malpractice*

☐ I have been the subject of a professional misconduct, incompetence, incapacity or other similar proceeding or investigation by any professional licensing or registration body other than the CRTO*

☐ Other events, circumstances, or conditions relevant to my competence, conduct or physical or mental capacity that might be relevant to my ability or suitability to function as a Respiratory Therapist*

*provide full particulars on a separate sheet of paper and attach to this form.

SIGNATURE: ______________________________ **DATE:** ____________________

MAIL: CRTO
2103-180 DUNDAS ST. W.
TORONTO, ON M5G 1Z8

FAX: (416) 591-7890

EMAIL: questions@crto.on.ca

QUESTIONS

If you have any questions contact us at: Telephone 416-591-7800 or toll free 1-800-261-0528; Email walsh@crto.on.ca