Labour Mobility Application

CRPO
College of Registered Psychotherapists of Ontario

NOTE: *Only those individuals who are currently a member in good standing of a statutory regulatory body within Canada,* ***but outside of Ontario****, are eligible to apply for registration with CRPO using the Labour Mobility Application.* ***Currently, three other provinces regulate practitioners who will be eligible to apply for registration with the College under labour mobility rules: New Brunswick, Nova Scotia and Québec. Members of College of Counselling Therapists of New Brunswick (CCTNB) and the Nova Scotia College of Counselling Therapists (NSCCT) will be eligible, as will holders of a Psychotherapy Permit in Québec.***

Ontario is a party to the national Agreement on Internal Trade (AIT), which provides for labour mobility of regulated professionals between provinces. In addition, Ontario passed its own *Labour Mobility Act* in 2009, implementing AIT. Under labour mobility laws, the College is legally required to accept the professional qualifications of individuals who hold "equivalent" certificates of registration in another Canadian province/territory and who have worked in that profession in their province within the previous three years. Applicants registered in another province or territory who wish to apply for registration with the College need not be using the title Registered Psychotherapist in the other jurisdiction. The determining factor will be whether the scope of practice in that jurisdiction is substantially equivalent to the scope of practice for RPs in Ontario.

COMPLETING THE LABOUR MOBILITY APPLICATION

All applicants for registration with CRPO, including those applying via labour mobility, must first create a user account on CRPO's Member Management System and complete the Professional Practice and Jurisprudence eLearning Module (JRP module), before they can submit an application. Click here to learn more about the JRP Module and creating an account.

Normally, applicants complete an electronic application found on our Member Management System. However, since an electronic application is not yet available for those applying via labour mobility, this fillable PDF form has been created for that purpose. Several steps must be completed before submitting your Labour Mobility Application form:

1. Create a user account
2. Apply to do the Jurisprudence e-Learning Module
3. Pay JRP invoice ($145.00 + HST)
4. Wait until your payment has been received by the College ("**Awaiting Payment**" will change to "**Payment Received**")
5. When you have successfully completed the JRP Module online, click the button that says "**Begin Regular Route Application.**" This will enable you to pay the $160 +HST application fee electronically (a necessary step).
6. Next, follow the instructions for paying the application fee, and await notification that the College has received your payment. Scan and upload a copy of the completed PDF form to the Documents tab.
7. Then, notify us using the Messaging function in the Member Management System (see "**Messages**" tab that your application has been uploaded and is ready for review by College staff

> NOTE: **All fields in the application must be completed**, as staff will use the information provided on your application to create an electronic file, and the process cannot be completed unless all fields are filled in. If a question is not relevant, please enter N/A or Not Applicable. Do not leave it blank.

Please monitor your email inbox for message alerts from the College; staff will contact you if any questions arise. You can check the status of your application by logging into your user account and viewing the **Application Status** indicator on the application landing page (page with links to the individual pages).

NOTE: Please save the form to your computer, then open with Adobe Reader, prior to filling out the form. If you fill out the form in your web browser, contents may not be saved.

1. PERSONAL INFORMATION

LEGAL NAME

First Name: Middle Name(s): Last Name:

COMMONLY USED NAME IN PRACTICE

First Name: Last Name:

PREVIOUS NAMES *(enter ALL legal names and assumed names, e.g. through marriage, since age 18)*

Date Name Last Used (e.g. Mar. 1, 2014)	First Name	Middle Name(s)	Last Name

Gender: ☐ Male ☐ Female

Date of Birth:

HOME ADDRESS

Street Address: Suite no:

City: Province: Postal Code: Country:

Primary Daytime Phone Number:

Alternate Phone Number:

Fax Number:

Email:

Email address for communicating with the College:

I would like the College to post my email address in the Public Register: ☐ Yes ☐ No

PREFERRED LANGUAGE

☐ English ☐ French

2. CURRENT AND PAST EMPLOYMENT IN PSYCHOTHERAPY

PLEASE DESCRIBE THE NATURE OF YOUR PSYCHOTHERAPY PRACTICE WITHIN THE THREE YEARS IMMEDIATELY PRIOR TO SUBMITTING YOUR APPLICATION FOR REGISTRATION WITH CRPO

Use **Page 2.A** to enter information about your current and past psychotherapy-related employer(s), making sure you identify your Current Primary Employer. **Employment includes being self-employed.** It also includes other non-employment settings where you have completed Direct Client Contact hours, e.g. seeing another therapist's clients in exchange for receiving Clinical Supervision.

Add current and/or past psychotherapy-related employers in the following order:

1. Add Current Primary Employer where you provide or supervise psychotherapy services.
2. Add other current employer(s) where you provide(d) or supervise(d) direct client services (**DO NOT** include other current employers if you have not provided or supervised direct client services).
3. If you are **not** currently employed, begin by adding past employers in reverse chronological order.
4. Add past employer(s), **ONLY** if you wish to include Direct Client Contact hours completed with one or more past employer(s); otherwise you do not need to include past employer(s).
5. To be eligible for 'independent practice,' i.e. practice without Clinical Supervision, you must have completed 1000 hours of Direct Client Contact **AND** 150 hours of Clinical Supervision since you commenced your education and training program in psychotherapy. Therefore, if you wish to qualify for 'independent practice,' please ensure that you document a minimum of 1000 hours of Direct Client Contact.

Please identify **only** one Current Primary Employer; if you are self-employed enter your business name as your employer. If you do not use a business name, enter your first and last name commonly used in practice.

2.A PRACTICE SITE DETAILS

If you have multiple entries, complete a separate detail page for each practice site.

EMPLOYER CONTACT INFORMATION

(If self-employed, enter your business name, or if you do not have a business name, your first and last name)

Employer Name:

Address:

City: Province: Postal Code: Country:

Does this Postal Code reflect the geographic location of your workplace? ☒ Yes ☐ No

If no, please provide the Postal Code for the geographic location of your workplace (for Ministry use only):

Practice Phone Number:

CONTACT NAME AT THIS EMPLOYER *(Manager, Supervisor, Department Head)*

If you are self-employed, enter your first and last name

First Name: Last Name:

Job Title:

Email Address:

Contact Phone Number:

This is my Current Primary Employer: ☐ Yes ☐ No

ROLE AND EMPLOYMENT PERIOD

Describe your role, including the client groups you serve and psychotherapy techniques you employ with them. If your role mainly involves supervising others who engage in direct client work, please include this aspect of your role:

Start Date:

End Date: *Leave blank if still employed here*:

HOURS OF DIRECT CLIENT CONTACT COMPLETE

Do you (or did you) engage in direct client work or supervise others who engaged in direct client work with this employer?

☐ Yes ☐ No

Hours of Direct Client Contact you completed with this employer:

3. CLINICAL SUPERVISION RECEIVED

Clinical Supervision can be individual, dyadic or group. Maximum group size is normally eight participants.

Group supervision may include structured peer group supervision, if the latter:

- is formal and structured; and
- includes at least one group member who meets the College's definition of a Clinical Supervisor (prior to proclamation, a practitioner who has extensive clinical experience, generally five years or more, in the practice of psychotherapy).

Structured peer group supervision differs from Group Clinical Supervision, in that the latter is led by a Clinical Supervisor, whereas the former includes at least one member who would qualify as a Clinical Supervisor but is an equal participant (not the leader). Structured peer group supervision often occurs in an institutional setting but may be formalized outside such settings.

Informal "peer supervision", i.e. unstructured discussion of clients with colleagues, is not considered an acceptable form of supervision for registration purposes.

Note: In some cases, you may not be able to identify specific dates, although you may be able to remember the year. Use your best estimate when you cannot remember a specific date. For 'independent practice,' i.e. practice without Clinical Supervision, you must have completed 150 hours Clinical Supervision over the course of your career to date **AND** 1000 hours of Direct Client Contact. Therefore, if you wish to qualify for 'independent practice,' please ensure that you document a minimum of 150 hours of Clinical Supervision, which can be recorded here. The maximum number of group supervision hours that can be counted for registration purposes is 50. The maximum number of group supervision hours that can be counted for purposes of meeting the 'independent practice' requirement is 75.

Until such time as you meet the overall 'independent practice' requirement, your Certificate of Registration will state that you must practise with Clinical Supervision. This will also be noted on the Public Register.

Use **Page 3.A** to provide details of supervision received for each period of Clinical Supervision you wish to include. This may require re-entering information about a supervisor more than once.

ONGOING CLINICAL SUPERVISION

If you have not completed 1000 hours of Direct Client Contact and 150 hours of Clinical Supervision as required for independent practice, enter the name, phone number and email address of each Clinical Supervisor with whom you expect to engage in regular Clinical Supervision following your registration with CRPO.

ONGOING CLINICAL SUPERVISOR NO. 1

First Name: Last Name:

Job Title:

Email Address:

Phone Number:

ONGOING CLINICAL SUPERVISOR NO. 2

First Name: Last Name:

Job Title:

Email Address:

Phone Number:

ONGOING CLINICAL SUPERVISOR NO. 3

First Name: Last Name:

Job Title:

Email Address:

Phone Number:

If you are unable to provide the information requested above, explain the reasons and describe your plan for obtaining regular Clinical Supervision following registration with CRPO.

3.A CLINICAL SUPERVISION RECEIVED DETAIL

If you have multiple entries, complete a separate detail page for each entry

DATES

Start Date of Clinical Supervision (e.g. Mar. 1, 2014):

End Date of Clinical Supervision (e.g. Mar 1, 2014):

CLINICAL SUPERVISION TYPE *(select one)*

- ☐ Clinical (individual or dyadic)
- ☐ Clinical (group)
- ☐ Clinical (structured peer group)

HOURS OF CLINICAL SUPERVISION RECEIVED

CLINICAL SUPERVISOR

First Name: Last Name:

Job Title:

Email Address:

Phone Number:

CLINICAL SUPERVISOR'S ACADEMIC CREDENTIALS AND PROFESSIONAL DESIGNATION

Academic Credentials, including field of study
(e.g. Dipl (TIRP), MSW, MA Education Counselling, MSc Couple & Family Therapy):

Designation (e.g. RMFT, CCC, MTA):

DESCRIBE THE SUPERVISORY RELATIONSHIP BELOW, INCLUDING:

- how you came to choose this supervisor;
- where and how often you meet/met;
- general nature of issues discussed; and
- if group supervision, number of supervisees in the group.

4. PROFESSIONAL AND OTHER CONDUCT

The College requires you to provide information about your Professional Conduct related to your registration/licensure with any statutory regulatory body, as well as information about any criminal or other offences. Please provide details of your past or present membership in any statutory regulatory body, findings of misconduct, professional negligence or malpractice and findings related to criminal and other offences.

Note: You must notify the College, immediately and in writing, of any changes to the information provided in your application related to your professional or other conduct.

Are you currently a member of a statutory regulatory body for any profession, in any jurisdiction?

☐ Yes ☐ No If Yes, complete **Page 4.A** as many times as necessary.

Have you been a member of any statutory regulatory body in the past?

☐ Yes ☐ No If Yes, complete **Page 4.B** as many times as necessary.

Have you ever been refused registration in any statutory regulatory body?

☐ Yes ☐ No If Yes, complete **Page 4.C** as many times as necessary.

Have you been found guilty of a criminal offence, or an offence that resulted in a fine over $1000 or imprisonment? Note: imprisonment includes a sentence served in the community, such as house arrest.

☐ Yes ☐ No If Yes, complete **Page 4.D** as many times as necessary.

Have you ever had a finding of professional negligence or malpractice made against you in any jurisdiction? Is there anything else currently or in the past, including actions or findings related to your membership in any professional association, that would call into question your ability to practise psychotherapy safely and professionally?

☐ Yes ☐ No If Yes, complete **Page 4.E** as many times as necessary.

Do you currently suffer from any physical or mental condition or disorder that may impair your ability to practise psychotherapy safely and competently, and which, if left untreated, would impair your ability to practice psychotherapy?

☐ Yes ☐ No If Yes, please provide details below

4.A CURRENT MEMBERSHIP IN STATUTORY REGULATORY BODY DETAIL

If you have multiple entries, complete a separate detail page for each entry

Are you currently a member of a statutory regulatory body? ☐ Yes ☐ No

Please complete a separate detail page for each statutory regulatory body of which you are a member

STATUTORY REGULATORY BODY INFORMATION

Name of Statutory Regulatory Body:

Street Address:

City: Province: Postal Code: Country:

Primary Phone Number:

Registration/License Number:

Date First Registered/Licensed (e.g. Mar 1, 2014):

Have you ever been found to have engaged in professional misconduct or found to have been incompetent or incapable, or any similar finding, or are there any current or pending proceedings for professional misconduct, or incompetence, or incapacity, or any similar proceedings against you?

☐ Yes ☐ No

Please describe any past findings of professional misconduct, incompetence or incapacity or any such current or pending proceeding against you.

4.B PAST MEMBERSHIP IN STATUTORY REGULATORY BODY DETAIL

If you have multiple entries, complete a separate detail page for each entry

Have you been a member of any statutory regulatory body IN THE PAST? ☐ Yes ☐ No

Please complete a separate form for each statutory regulatory body of which you have been a member in the past.

PAST STATUTORY REGULATORY BODY INFORMATION

Name of Past Statutory Regulatory Body:

Street Address:

City: Province: Postal Code: Country:

Primary Phone Number:

Registration/License Number:

Date First Registered/Licensed (e.g. Mar 1, 2014):

Registration/Licensing End Date (e.g. Mar. 1, 2014):

Have you ever been found to have engaged in professional misconduct or found to have been incompetent or incapable, or any similar finding, or are there any current or pending proceedings for professional misconduct, or incompetence, or incapacity, or any similar proceedings against you?

☐ Yes ☐ No

Please describe any past findings of professional misconduct, incompetence or incapacity or any such current or pending proceeding against you.

4.C REFUSAL OF REGISTRATION/LICENSING DETAIL

If you have multiple entries, complete a separate detail page for each entry

Have you ever been REFUSED registration or licensing by any statutory regulatory body? ☐ Yes ☐ No

Please complete this page for each statutory regulatory body that has refused you membership.

STATUTORY REGULATORY BODY INFORMATION

Name of Statutory Regulatory Body:

Street Address:

City: Province: Postal Code: Country:

Primary Phone Number:

Date of Refusal (e.g. Mar. 1, 2014):

Reason for Refusal

4.D OFFENCES

Complete a separate page for each offence

Have you been found guilty of a criminal offence, or an offence that resulted in a fine over $1000 or imprisonment?

☐ Yes ☐ No

Note: imprisonment includes a sentence served in the community, such as house arrest.

Date of finding of guilt (e.g. Mar. 1, 2014):

Please provide the details of this offence, including the address of the courthouse where the finding was made and details of the sentence.

4.E OTHER ACTION OR FINDINGS DETAIL

If you have actions or findings, complete a separate detail page for each action or finding

Have you ever had a finding of professional negligence or malpractice made against you in any jurisdiction? Or is there anything else currently or in the past that could call into question your ability to practise psychotherapy safely and professionally?

X Yes No

Though not exhaustive, this might include a complaint, discipline or dismissal involving:

- **a professional association;**
- **an employer;**
- **an educational institution.**

It would also include any other conduct that, if known, would cause the College to call into question your ability to practise psychotherapy safely and professionally.

Date of Occurrence (e.g. Mar. 1, 2014):

Please provide the details of any such occurrence below:

5. HEALTH PROFESSIONS DATABASE QUESTIONS

Required by Ministry of Health and Long Term Care

Did you complete a Bridging Program in English or French? *(instruction and client care)* ☐ Yes ☒ No
(Bridging programs help integrate internationally-trained practitioners into the Ontario workplace.)

If you selected 'Yes', what year did you complete the bridging program?

I use the following languages competently and with reasonable fluency when providing psychotherapy services:

1. 2. 3. 4.

I would like the College to post on the Public Register the languages I use competently when providing psychotherapy services:
☐ Yes ☐ No

PRACTICE HISTORY

Note: Practising the profession means practising within the scope of practice of psychotherapy, as defined in the *Psychotherapy Act, 2007*.

First year practising the profession (YYYY): 2017

Country of first time practising the profession:

Province, Territory or State of first practising the profession:

First year practising the profession in Canada (YYYY): 2017

Location of first practising the profession in Canada (Province or Territory):

Most recent previous country practising the profession:

Most recent previous Province, Territory or State of practising the profession:

Last year practising the profession in previous Province, Territory or State (YYYY): 2017

REGISTRATION TO PRACTISE PSYCHOTHERAPY IN OTHER JURISDICTIONS

I am currently registered/licensed to practice psychotherapy/clinical counselling in a Canadian province or territory other than Ontario, or an American state. ☐ Yes ☐ No

If Yes, in which Province(s), State(s) or Territories are you registered/licensed?
1. 2. 3.

I am currently registered/licensed to practice psychotherapy/clinical counselling in countries other than Canada.
☐ Yes ☐ No

If Yes, in which countries are you registered/licensed?
1. 2. 3.

EDUCATION AND TRAINING

Please use the following list to complete information concerning your education and training:

Levels of Education

1. Diploma
2. Baccalaureate
3. Master
4. Professional Doctorate
5. Doctorate
6. Entry to Practice Post Diploma Certificate/Courses
7. None of the Above
8. Not Applicable

EDUCATION IN THE PROFESSION *(Include your five highest levels of training in the profession)*

Level of Education in the Profession:

Name of School/Institution at Graduation:

City: Province: Country: Year Completed:

Level of Education in the Profession:

Name of School/Institution at Graduation:

City: Province: Country: Year Completed:

Level of Education in the Profession:

Name of School/Institution at Graduation:

City: Province: Country: Year Completed:

Level of Education in the Profession:

Name of School/Institution at Graduation:

City: Province: Country: Year Completed:

Level of Education in the Profession:

Name of School/Institution at Graduation:

City: Province: Country: Year Completed:

Please use the following list to complete information concerning your education and training:

Fields of Study

1. General Rehabilitation Science
2. Medical Laboratory Science
3. Mathematics, Computer Information Sciences
4. Health Administration/Management
5. Public Administration
6. Public Health
7. Kinesiology and Exercise Science
8. Gerontology
9. Psychology
10. Health Professions and Related Clinical Sciences
11. Biological and Biomedical Sciences
12. Physical Sciences
13. Social Sciences, Arts and Humanities
14. Education
15. Law
16. Business, Management, Marketing and Related
17. Engineering
18. Other Field of Study

EDUCATION OUTSIDE THE PROFESSION

Highest level of education outside the profession:

Field of study for highest education outside the profession:

Year of graduation:

Province/Territory/State of graduation: Country of graduation:

6. PROFESSIONAL LIABILITY INSURANCE

Note: You may be subject to discipline if you practise without professional liability insurance that meets the requirements of the College.

I have professional liability insurance for each current employer/practice site that meets the requirements of the College.

☐ Yes ☐ No

If you selected Yes, complete **Part A** for all current practice sites. If you selected No, skip to **Part B**, to agree to an undertaking to provide proof of professional liability insurance.

PART A

- Provide name of the insurance company or underwriter **not the insurance broker**.
- Provide the policy number, **not the certificate number**.
- Enter the address of the practice site to which your insurance coverage applies. **Ensure that all current practice sites mentioned in your application are covered on this page**. You may need to repeat the same insurance policy in more than one entry in order to cover all practice sites.

If you have professional liability insurance for each current employer/practice site that meets the requirements of the College, include the insurance information below.

Name of Insurer/Underwriter	Policy Number	Policy Expiry Date	Practice Site

PART B

I undertake to provide the College with proof of professional liability insurance that meets the coverage requirements of the College for each current employer/practice site, within 30 days of registration (coverage effective from the date of registration). I understand that my membership in the College will be suspended if I do not provide proof of liability insurance within 30 days of registration.

Signature of Applicant: Date:

7. REQUIRED DOCUMENTS

GENERAL DECLARATION AND CONSENT TO THE RELEASE OF INFORMATION

Each applicant is required to complete a **General Declaration and Consent to the Release of Information**, in which s/he provides his/her written consent to allow the College to contact and/or request information from any individual or organization relevant to the application, e.g. the College may contact current or past employers, supervisors, educational institutions, professional associations, etc., to verify the information.

STATUTORY DECLARATION

Each applicant is required to complete a **Statutory Declaration** attesting to the truthfulness of all information submitted as part of their Application for Registration or in support of their application, i.e. attesting that it is complete and accurate to the best of their knowledge. Please download and print the **Statutory Declaration Template**, complete it and have it signed by an authorized individual. e.g. Commissioner of Oaths, lawyer, notary public, judge. You will be required to make the declaration before the commissioner, and to provide government- issued photo ID (e.g. passport, driver's license). **Important: Do not** date and sign the Statutory Declaration prior to seeing the commissioner.

Note: It is a criminal offence to sign a false statutory declaration.

GENERAL DECLARATION AND CONSENT TO THE RELEASE OF INFORMATION

I, ____ (name of applicant) acknowledge that I am not permitted to practise as a Registered Psychotherapist, to use any protected title * or hold out as qualified to practise as a psychotherapist in Ontario unless I have received written notification that I have been registered with the College.

I acknowledge that the personal information provided on this form is used by the College to administer the *Regulated Health Professions Act, 1991*, the *Psychotherapy Act, 2007*, the Regulations, the By-laws, the policies, the Standards of Practice, and for research and other projects related to the governance of Registered Psychotherapists, and that it is collected, used, and disclosed in accordance with the College's Privacy Code.

I promise to immediately inform the College in writing if any of the information in this application changes. For example, I will report if, after submitting this form, I am referred to a hearing for allegations of professional misconduct, incompetence, incapacity or like allegations, by a statutory regulatory body. I further understand that even after I am registered I must notify the Registrar in writing within thirty days of any change of home, business or employment address, email address, or telephone number.

I authorize the College to obtain information from other regulatory bodies, educational institutions, present and former employers, referees, any of my past and/or present treating regulated health practitioners and any other sources for the purposes related to my application for registration, including information about any education or experience.

*Unless the applicant is a member of another regulated profession entitled to use a protected title.

I, ____ (name of applicant), hereby consent to the release to the College of Registered Psychotherapists of Ontario (CRPO) of any information or document, held by any party, related to my application for registration with the CRPO. This document shall be the authority for any party to release the information or document to the CRPO.

Signature of Applicant: Date:

STATUTORY DECLARATION

MESSAGE TO THE COMMISSIONER OF OATHS

The Declarant whose name appears below is applying for registration with the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario, a statutory regulatory body created in Ontario under authority of the Regulated Health Professions Act, 1991*, and the* Psychotherapy Act, 2007*. Kindly verify his or her identity and have the Declarant make this declaration in your presence.*

I, ____ <full legal name> solemnly declare:

that the information and supporting materials I have provided or will provide in my application for registration with the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario (CRPO) are truthful, accurate and complete to the best of my knowledge,

and

I understand that a false or misleading statement, by commission or omission, may disqualify me from registration or may be cause for revocation of my registration, should I be granted membership with the College,

and

I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath.

Signature of Declarant: Date:

Full name of Declarent <full legal name>:

Declared before me: (PRINT NAME OF COMMISSIONER)

at the (MUNICIPALITY TYPE) of (MUNICIPALITY NAME) this (DAY) day of (MONTH) , 20 (YEAR)

Signature of Commissioner:

Address of Commissioner:

City: Province: Postal Code: Country:

Tel. number of Commissioner:

Note: It is a criminal offence to knowingly make a false statutory declaration.