



OFFICE USE ONLY		
Application/Registration #:		
Date of Application Received:		
Month	Day	Year

APPLICATION FOR CERTIFICATE IN THE GENERAL CLASS OF REGISTRATION

Complete application form in full (**print clearly**)

Incomplete forms will delay the registration process (see the [Candidates' Guide](#))

If there are changes to any of the following information you must immediately provide written details to CTCMPAO

1. PERSONAL INFORMATION			
Legal first name		Previous first name	
Legal middle name (if any)		Previous middle name (if applicable)	
Legal last name		Previous last name (if applicable)	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Month Day Year	<input type="checkbox"/> Proof of identification (e.g. <u>notarized</u> copy of birth/marriage/divorce certificate, passport) (If you have previously submitted a notarized of identification to the College, you do not need to submit it again) <input type="checkbox"/> Name change documentation (if applicable)
2. PURSUING TITLE(S)			
<input type="checkbox"/> Traditional Chinese Medicine Practitioner			
<input type="checkbox"/> Acupuncturist			
3. HOME ADDRESS			
Home address Number Street		Apt/Suite/Unit	
City	Province/State (required)	Country (required)	Postal code/ ZIP Code (required)
Home telephone		Cell number	Fax number
Email * must be a unique email address and cannot be shared with another member of CTCMPAO			
4. PRIMARY BUSINESS/ PRACTICE ADDRESS (if applicable)			
Facility Name		Please be advised in accordance with the Health Professions Procedural Code , each registered member's name, primary business address and primary business telephone number will appear on CTCMPAO's public register .	
Number Street		Suite/Unit	
City	Province/State (required)	Country (required)	Postal code/ ZIP Code (required)
Telephone	Extension	Fax number	Website
Preferred contact information			
<input type="checkbox"/> Home			
<input type="checkbox"/> Primary Business			
5. PHOTO			
My attached photograph was taken on:			
Month	_____		
Day	_____		
Year	_____		
_____ Signature of Applicant			<div style="border: 2px solid black; padding: 20px; text-align: center;"> <p>Paste passport-size photo here</p> </div>

THIS APPLICATION IS VALID FOR 12 MONTHS FROM THE DATE OF SIGNING DECLARATION

6. POST-SECONDARY EDUCATION RELATED TO TCM/TCM ACUPUNCTURE

A. Education Program (Attach proof of education completion if not submitted previously)

First Traditional Chinese Medicine / Traditional Chinese Medicine Acupuncture Education Program

Name of program		Program Start date Month Day Year		Graduation date Month Day Year		
Name of education institution(s) attended				Total Program Hours		
Number	Street			Suite/Unit		
City		Province/State	Country		Postal Code/ Zip Code	

Second Traditional Chinese Medicine / Traditional Chinese Medicine Acupuncture Education Program (if applicable)

Name of program		Program Start date Month Day Year		Graduation date Month Day Year		
Name of education institution(s) attended				Total Program Hours		
Number	Street			Suite/Unit		
City		Province/State	Country		Postal Code/ Zip Code	

Third Traditional Chinese Medicine / Traditional Chinese Medicine Acupuncture Education Program (if applicable)

Name of program		Program Start date Month Day Year		Graduation date Month Day Year		
Name of education intuition(s) attend				Total Program Hours		
Number	Street			Suite/Unit		
City		Province/State	Country		Postal Code/Zip Code	

B. Supervised Clinical Experience in Direct Patient Contact (Attached proof of completion of supervised clinical experience if not submitted previously)

Have you completed a program of clinical experience in the Traditional Chinese Medicine profession that is structured, comprehensive, supervised and evaluated, which consists of at least 45 weeks of clinical experience involving at least 500 hours of direct patient contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the program in clinical experience commence before your post-secondary education related to Traditional Chinese Medicine or Traditional Chinese Medicine Acupuncture?	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. COMPLETION OF JURISPRUDENCE COURSE AND SAFETY PROGRAM

Successfully completed the Jurisprudence Course Test	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Test Month Day Year
Successfully completed the Safety Program Test	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> R. TCMP <input type="checkbox"/> R. Ac
	Date of Test Month Day Year	

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8. REGISTRATION EXAMINATIONS

Successfully completed the registration written examination approved by CTCMPAO	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> R. TCMP
	Date of examination Month Day Year	<input type="checkbox"/> R. Ac
Successfully completed the registration clinical case-study examination approved by CTCMPAO	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> R. TCMP
	Date of examination Month Day Year	<input type="checkbox"/> R. Ac

9. LANGUAGE FLUENCY

Able to speak, read and write with reasonable fluency in English	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Able to speak, read and write with reasonable fluency in French	<input type="checkbox"/> Yes	<input type="checkbox"/> No

10. ADDITIONAL LANGUAGES

Additional languages you can personally and competently provide professional services (up to 4):

1. _____	2. _____
3. _____	4. _____

I agree to allow information regarding my ability to personally and competently provide professional services in the additional languages noted above to be disclosed on the public register	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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11. REGISTRATION IN OTHER PROFESSIONS (if applicable)

Are you registered with another regulated profession in Ontario? Please one box only

Yes (indicate below)

No (skip to next section)

Ensure that the initial date of registration follows the format requested and that the declaration of conduct, section 15, question J is consistent with the information provided in the chart below, otherwise your application will be inaccurate.

Regulatory Body	Registration /Licence No.	Date of Initial Registration (MM / DD/ YY)	Regulatory Body	Registration /Licence No.	Date of Initial Registration (MM/ DD/ YY)
<input type="checkbox"/> College of Audiologists and Speech -Language Pathologists			<input type="checkbox"/> College of Physiotherapists		
<input type="checkbox"/> College of Chiropractors			<input type="checkbox"/> College of Psychologists		
<input type="checkbox"/> College of Chiropractors			<input type="checkbox"/> College of Registered Psychotherapists		
<input type="checkbox"/> College of Dental Hygienists			<input type="checkbox"/> College of Respiratory Therapists		
<input type="checkbox"/> College of Dental Technologists			<input type="checkbox"/> Association of Architects		
<input type="checkbox"/> Royal College of Dentist Surgeons			<input type="checkbox"/> Institute of Chartered Accountants		
<input type="checkbox"/> College of Denturists			<input type="checkbox"/> Association of Certified Engineering Technicians and Technologists		

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Regulatory Body	Registration /Licence No.	Date of Initial Registration (MM / DD/ YY)	Regulatory Body	Registration /Licence No.	Date of Initial Registration (MM / DD/ YY)
<input type="checkbox"/> College of Dietitians			<input type="checkbox"/> College of Early Childhood Educators		
<input type="checkbox"/> College of Homeopaths			<input type="checkbox"/> Professional Engineers		
<input type="checkbox"/> College of Kinesiologists			<input type="checkbox"/> Professional Foresters Association		
<input type="checkbox"/> College of Massage Therapists			<input type="checkbox"/> Certified General Accountants		
<input type="checkbox"/> College of Medical Laboratory Technologists			<input type="checkbox"/> Association of Professional Geoscientists		
<input type="checkbox"/> College of Medical Radiation Technologists			<input type="checkbox"/> Association of Land Surveyors		
<input type="checkbox"/> College of Midwives			<input type="checkbox"/> Law Society of Upper Canada		
<input type="checkbox"/> College of Naturopaths			<input type="checkbox"/> Certified Management Accountants		
<input type="checkbox"/> College of Nurses			<input type="checkbox"/> College of Social Workers and Social Service Workers		
<input type="checkbox"/> College of Occupational Therapists			<input type="checkbox"/> College of Teachers		
<input type="checkbox"/> College of Opticians			<input type="checkbox"/> College of Trades		
<input type="checkbox"/> College of Optometrists			<input type="checkbox"/> College of Veterinarians		
<input type="checkbox"/> College of Pharmacists			<input type="checkbox"/> Others:		
<input type="checkbox"/> College of Physicians and Surgeons			<input type="checkbox"/>		

12. REGISTRATION OUTSIDE ONTARIO (if applicable)

Are you registered with another regulated health profession including Traditional Chinese Medicine profession outside of Ontario? Please one box only

- Yes (indicate below)
 No (skip to next section)

Regulatory Body	Registration /Licence No.	Date of Initial Registration (MM / DD/ YY)	Province/State	Country

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13. CURRENCY REQUIREMENT (if applicable)

Did you submit the General Class application within 5 years of successful completion of your post-secondary program in traditional Chinese medicine or traditional Chinese medicine acupuncture AND within 12 months of passing the Registration Examination?

Yes No If "no," complete either **Section A** or **Section B** below.

A. Refresher Program

Have you successfully completed a refresher program (approved by the Registration Committee) within the 12-month period that immediately precedes the date that you submitted your application?

Yes No If "yes", skip to section 14. Professional Liability Insurance.

OR

B. Practice Information

Have you practised traditional Chinese medicine and/or traditional Chinese acupuncture within the last three (3) years? (Please note that these visits do not include the patient visits obtained during your clinical experience from your TCM program.)

Yes No If "yes", complete the section B

	Month	Day	Year		Month	Day	Year
From				To			

Did the practice include a minimum of [500 TCM patient visits](#) (which may include TCM acupuncture patient visits)?

Yes No

The patient visits must have occurred between the dates shown above. They may have occurred inside or outside of Canada

Validation of Traditional Chinese Medicine and/or Traditional Chinese Acupuncture Patient Visits (Please only complete this section if you answered "Yes" for Section 13B.)

"I hereby certify that I have completed a minimum of 500 traditional Chinese medicine patient visits and/or traditional Chinese acupuncture patient visits within the past 3 years that meets the definition of [patient visits](#) approved by the Registration Committee of CTCMPAO. I understand that providing false or misleading information about my patient visits is grounds for denying my application or revoking my registration. I further understand that CTCMPAO may inspect original patient records to verify patient visits information, if necessary."

Signature of Applicant			
Date of signature	Month	Day	Year

14. PROFESSIONAL LIABILITY INSURANCE

Please confirm and complete the section below.

- I hereby certify that I will have the professional liability insurance in accordance with [CTCMPAO By-laws](#) and [Registration Policy on Professional Liability Insurance](#) as of the anticipated date of the issuance of a certificate;
- I confirm that my professional liability insurance will meet the minimum required coverage:
 - No less than \$1,000,000 coverage per claim
 - Aggregate coverage no less than \$5,000,000
 - No more than \$1,000 deductible per claim

- I have attached a photocopy of the Certificate of Insurance to this application form, OR
- I will submit a photocopy of the Certificate of Insurance within thirty (30) days after the registration is **approved**.

Signature of Applicant	Date of signature	Month	Day	Year
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15. DECLARATION OF CONDUCT

a. Have you ever been found guilty of any non-criminal offence that resulted in a fine of over \$1,000 or any form of custody or detention or had a finding of guilt for a criminal offence in Ontario or in any other jurisdiction in or outside Canada? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has there ever been a finding of professional negligence or malpractice against you? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Has there ever been any finding of professional misconduct, incompetence or incapacity, or similar finding against you by any regulatory body in Ontario or in any other jurisdiction? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Is there currently a proceeding against you involving an allegation of professional misconduct, incompetence or incapacity, or any similar proceeding by any regulatory body in Ontario or in any other jurisdiction? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have you ever made an application for registration as a Traditional Chinese Medicine Practitioner and/or Acupuncturist in any other jurisdiction that was refused? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Have you ever had an application for registration rejected by a regulatory college in Ontario or in another province? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Have you ever been unsuccessful in an attempt to pass a registration examination for a regulated health profession in Ontario or in another jurisdiction? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Has there ever been a court proceeding brought against you alleging that you held yourself out as, or practising as a regulated health professional without being so registered? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Do you currently suffer from any physical or mental condition or disorder which may impair your ability to practise traditional Chinese medicine safely and competently and which, if left untreated, would impair your ability to practise traditional Chinese medicine safely and competently? <i>If you answered "yes" to question 15.i, attach a detailed explanation to this application and arrange for your treating regulated health professional(s) to send directly to CTCMPAO a report on your condition or disorder setting out your diagnosis, course of treatment and current health prognosis. Where appropriate, this report should indicate any accommodation(s) that your regulated health professional deems necessary in order for you to practise in a safe manner. CTCMPAO might require further information from your past and/or present treating regulated health professional and will contact him or her, if necessary. In submitting this form, you are providing your authorization to your past and/or present treating regulated health professional to disclose further information to CTCMPAO.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. If you were registered with a body responsible for the regulation of a profession, and you ceased being registered, were you in good standing, (i.e., all fees paid, all information provided, no outstanding investigations, proceedings or sanctions) at the time you ceased being registered? If no , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
k. If you are a member of a regulated profession, are you in good standing, (i.e., all fees paid, all information provided, no outstanding investigations, proceedings or sanctions)? If no , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
l. If you are a member of a regulated profession, did you ever fail to comply with any obligation to pay fees or provide information to the regulator? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
m. If you are a member of a regulated profession, has an investigation by the regulator ever been initiated in respect of you? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
n. If you are a member of a regulated profession, has the regulator ever imposed a sanction on you? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
o. Is there any other event that would provide reasonable grounds that you will not practise traditional Chinese medicine in a safe and professional manner? If yes , attach a detailed explanation and relevant documents to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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16. CRIMINAL BACKGROUND CHECK

Attach an **original (NOT a copy)** [criminal background check report](#) using the Canadian Police Information Centre (CPIC) database.

NOTE: The name appearing on the Criminal Background Check report must match the name appearing on the registration application. The report must also indicate that a search was completed on all names the applicant is currently using or has used.

17. HEALTH PROFESSION DATABASE

A. Practice History

If you previously practised **only outside of Canada**, indicate the country where you practised most recently

Country

OR

If you previously practised **only outside of Ontario, but within Canada**, indicate the province/ territory where you practised most recently

Province/Territory

Not applicable

Last year in which you practised in your most recent location **outside of Ontario**, if applicable

B. Education other than Traditional Chinese Medicine Qualifications

Check **only** the highest level of education completed that was **unrelated** to TCM and/ or traditional Chinese acupuncture qualifications:

Diploma Baccalaureate Master Doctorate Professional Doctorate

Other: _____

Country of Graduation for **highest** level of education completed that was **unrelated** to TCM and/or traditional Chinese acupuncture qualifications:

Canada Province/Territory, if education completed in Canada: _____
 USA State(s) if education completed in the USA: _____
 Other (Specify): _____

Year of graduation for **highest** level of education completed that was **unrelated** to TCM and/or traditional Chinese acupuncture qualifications:

Field of study for **highest** level of education completed that was **unrelated** to TCM and/or traditional Chinese acupuncture qualifications:

- | | |
|---|---|
| <input type="checkbox"/> General Rehabilitation Science | <input type="checkbox"/> Mathematics, Computer Information Sciences |
| <input type="checkbox"/> Medical Laboratory Science | <input type="checkbox"/> Health Administration/Management |
| <input type="checkbox"/> Public Administration | <input type="checkbox"/> Kinesiology and Exercise Science |
| <input type="checkbox"/> Public Health | <input type="checkbox"/> Health Professions and Related Clinical Sciences |
| <input type="checkbox"/> Gerontology | <input type="checkbox"/> Biological and Biomedical Sciences |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Social Sciences, Arts and Humanities |
| <input type="checkbox"/> Physical Sciences | <input type="checkbox"/> Business, Management, Marketing and Related |
| <input type="checkbox"/> Education | <input type="checkbox"/> Law |
| <input type="checkbox"/> Engineering | <input type="checkbox"/> Other Field of Study |

18. EMPLOYMENT

Is this the first time you will practise the TCM profession?

Yes No

If no, in which country and year did you first begin to practise in the TCM profession?

<input type="checkbox"/> Canada	Province/Territory, if education completed in Canada: _____	Year: _____
<input type="checkbox"/> USA	State(s) if education completed in the USA: _____	Year: _____
<input type="checkbox"/> Other (Specify): _____		Year: _____

If the country where you **first** practised the TCM profession was **not Canada** provide the first Canadian province/territory of practise in the profession: _____

In which year did you first begin to practise the TCM profession **in Canada**? _____

19. APPLICANT'S DECLARATION

I solemnly declare that the contents of this application including all attachments are true and complete to the best of my knowledge and belief.

I understand that I am not permitted to perform any of the authorized controlled acts, use any of the restricted titles or hold myself out as a member of CTCMPAO unless I have received written notification that I have been registered with CTCMPAO.

I understand and agree that if I make any false or misleading statement or representation on or in connection with my application, I shall be deemed not to have satisfied the registration requirements for a Certificate of Registration. I further understand and agree that if the Certificate of Registration should be issued to me based upon any false or misleading statement or representation, the Certificate of Registration can be immediately revoked and I may face disciplinary proceedings.

I acknowledge that the information provided on this form is used by CTCMPAO to administer the [Regulated Health Professions Act, 1991](#), the [Traditional Chinese Medicine Act, 2006](#), the Regulations under these Acts, the By-Laws, policies, [Standards of Practice](#) and programs related to the governance of the profession; and that the information is collected, used and disclosed in accordance with the [Health Professions Procedural Code](#) and the [CTCMPAO By-Laws](#).

I promise to immediately inform CTCMPAO in writing if any of the information on this form 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 (30) days of any change of residential, business or employment address, email address or telephone number.

I authorize CTCMPAO 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 any experience and qualifications.

I authorize my past and/or treating regulated health practitioners to disclose personal health information to CTCMPAO for the purposes related to my application for registration.

Taken and declared before me in the city/town of

City/ Town	Province/ State	Country
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this _____ Day of _____ 20 _____

Full legal name of Applicant	Signature of Applicant
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Signed _____
 Commissioner of Oaths, Notary Public, Lawyer
 (Official seal/stamp or business card must be provided/attached to this sheet)

NOTE: Section 19 needs to be notarized by a Commissioner of Oaths, Notary Public, or Lawyer along with your signature.

THIS APPLIATION IS VALID FOR 12 MONTHS FROM THE DATE OF SIGNING DECLARATION

20. PAYMENT OF FEES

In order for your application to be processed you must include the **\$250.00** application fee. Once your application has been approved you will be required to submit the registration fee. The application fee is non-refundable.

Payment Method 1 - Credit Card

Visa MasterCard

2019-2020 Application Fee for a Certificate in the General Class of Registration: **\$250.00**

2019-2020 Registration Fee will be required when all regulation registration requirements have been met

Declined credit card payment will incur an additional service charge.

Name		Application Number
Card number	Expiration date on card Month Year	Name on Card (PLEASE PRINT)
By my signature, I authorize the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario to charge my Visa or MasterCard account with the amount of \$250.00 in Canadian funds.		Signature
		Date

Payment Method 2 - Certified Cheque/Money Order

A certified cheque or money order payable to College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario for a full amount of **\$250.00** in Canadian Funds Only, with application number printed on the front of your payment.

2019-2020 Application Fee for a Certificate in the General Class of Registration: **\$250.00**

2019-2020 Registration Fee will be required when all regulation registration requirements have been met

21. 2019-2020 FEES

Fees Relating to General Class

Item	Total Fee
Application*	\$250.00
Initial Registration (first year of registration pro-rated by quarter in which registered)	
April 1, 2019 - June 30, 2019	\$1300
July 1, 2019 - Sept 30, 2019	\$975.00
October 1, 2019 - December 31, 2019	\$650.00
January 1, 2020 - March 31, 2020	\$325.00

The College has removed the harmonized sales tax (HST) on all fees, effective February 1, 2019.

*All application fees are non-refundable

Mail your complete application with payment and all necessary documents to:

Registrar
CTCMPO
705-55 Commerce Valley Drive West
Thornhill, ON L3T 7V9

Checklist of Information/Documents to Submit

- Attached a payment for
 - Application Fee **\$250.00**

2019-2020 Registration Fee will be required when all regulation registration requirements have been met
- Provided evidence of identity (e.g. a notarized copy of birth certificate, passport, marriage certificate, divorce decree or a validation of identity **signed by Commissioner of Oaths, Notary Public, Lawyer**) If you have previously submitted this document to the College, you do not need to submit it again.
- Provided name change documentation (**if applicable**)
- Provided contact information
- Provided Email address
- Attached a passport-size photograph
- Post-secondary education related to traditional Chinese medicine/traditional Chinese acupuncture
- Proof of Education Completion (**You must attach all of the following documentations if NOT submitted previously**)
 - Attached a notarized copy of your degree, certificate or diploma in traditional Chinese medicine acupuncture **or** provide an original letter from your educational institution confirming successful completion of the program; **and**
 - Attached a notarized copy of your academic transcript of marks; **and**
 - Attached a detailed curriculum or course outline for your program, certified by your educational institution, including a detailed list of courses and a description of the content of each course completed during your education and training, including the number of clock hours.
- Supervised clinical experience
- Proof of Successful Completion of Supervised Clinical Experience (**You must attach all of the following documentations if NOT submitted previously**)
 - An original letter from educational intuition/supervisor confirming successful completion of 500 hours **direct patient contact within 45 weeks of clinical experience** in the TCM profession including a detailed description of the supervised clinical experience, **showing** the number of clock hours in direct patient contact and number of weeks spent in clinical training/ experience. The letter must include the name and registration number of the supervisor with CTCMPAO
- Jurisprudence course test and safety program test completion
- Registration Examinations – Pan-Canadian Examinations completion

- Indicated language fluency

- Provided Professional Liability Insurance

- Completed all declaration of conduct questions

- Attached an **original** criminal background check report

- Completed all applicable Health Profession Database questions

- Applicants declaration signed and dated