



# New Registrant Application Form

## Personal Information

<input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.	Legal First Name	Middle Name	Legal Last Name
Commonly Used FIRST Name in Practice		Commonly Used LAST Name in Practice	Previous Name(s)
Home Address (Street Name, Number, Unit/Apartment)			
City	Province/Territory		Country
Postal Code	Telephone	Cell Phone	
Preferred Email: An email address is required for PEICOT to communicate with you.		Date of Birth D/ M/ Y/	<input type="checkbox"/> Female <input type="checkbox"/> Male

## Labour Mobility Support Agreement (LMSA)

Are you applying under the LMSA?  Yes  No If Yes, indicate the province you are coming from \_\_\_\_\_

Mobility Provisions: Applicants currently registered with another OT regulatory organization in Canada may be eligible to apply under the Labour Mobility Support Agreement (LMSA). Contact the College for more information.

## Registration Category (please check one only)

Full Registration  Provisional Registration

## English Language Proficiency Requirement

First Language \_\_\_\_\_ Language of OT Instruction \_\_\_\_\_

Other Languages you can practice in \_\_\_\_\_

Note: If first language or language of instruction is not English, evidence of English proficiency is required.

## OT Entry Level Education Please indicate the education you attained to enter the profession of occupational therapy

<input type="text"/>	University	Prov/State/Country	Year of Graduation
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Degree/Diploma Codes: 10 Diploma 20 Baccalaureate 31 Master's (entry to profession) 41 Doctorate (entry to profession)

Did you complete the required 1000 hours of fieldwork with your OT Program?  Yes  No

## OT Post Entry Level Education Please indicate any other OT education you have attained (attach separate sheet if required)

<input type="text"/>	University	Prov/State/Country	Year of Graduation
<input type="text"/>	University	Prov/State/Country	Year of Graduation

Degree/Diploma Codes: 20 Baccalaureate 32 Master's (post entry) 40 Doctorate

## Education other than OT Please indicate all your education experience other than Occupational Therapy

<input type="text"/>	University	Field of Study	<input type="text"/>	Prov/State/Country	Year of Graduation
<input type="text"/>	University	Field of Study	<input type="text"/>	Prov/State/Country	Year of Graduation

Degree/Diploma Codes: 10 Diploma 20 Baccalaureate 30 Master's Degree 40 Doctorate



**Field of Study**

**010:** General Rehabilitation Science

**020:** Health Administration/ Management

**030:** Public Administration

**040:** Public Health

**050:** Kinesiology & Exercise Sciences

**060:** Gerontology

**070:** Psychology

**080:** Health Professions & Related Clinical Sciences

**090:** Biological & Biomedical Sciences & Physical Sciences

**100:** Social Sciences, Arts & Humanities

**110:** Education

**120:** Law

**130:** Business Management, Marketing & Related

**140:** Other Field of Study

**National Occupational Therapy Certification Examination (NOTCE) Formerly CAOT Exam**

I passed the NOTCE on: Exam Date: \_\_\_\_\_ Other: \_\_\_\_\_

I am registered to write the NOTCE on: ExamDate: \_\_\_\_\_

I was not successful writing the NOTCE on: (please list all attempts). ExamDate: \_\_\_\_\_

## New Registrant Application Form

### Currency Hours      section must be completed each year of registration

- |  |   |
|--|---|
| <input type="checkbox"/> In the immediate past five years, I have worked at least 1000 hours<br><input type="checkbox"/> In the immediate past three years, I have worked at least 700 hours<br><input type="checkbox"/> I do NOT meet any of the above currency requirements and require a review | <input type="checkbox"/> I completed an approved re-entry program in the past 18 months<br><input type="checkbox"/> I graduated within the past 18 months |
|--|---|

### Record of Professional Development/Continuing Education

Please list your credit hours for the year 2016-2017. You **MUST** attach a certificate of attendance or credit hour proof, along with the agenda of any courses/workshops/conferences you have attended in the past year. Inservices and teleconferences can be included as well; a copy of a sign in sheet or equivalent is required as proof of attendance to these type of education opportunities. CPR and safety courses such as WHIMIS cannot be counted towards the **10 credit hours** (or 30 hours in the previous 3 years) that are required annually.

DATE(S)	COURSE TITLE	COURSE SPONSOR/HOST	LOCATION	CREDIT HOURS
Example May 23-25	Driving for Older Adults - Preconference Workshop	CAOT	Fredericton, NB	15
<b>2017</b>	<b>TOTAL CREDIT HOURS FOR THE YEAR 2016-</b>			

### Employment Profile

The College is required to maintain a public register. Your name, registration status and business information may be provided upon request

- |                          |                       |                          |  |
|--------------------------|-----------------------|--------------------------|--|
| <input type="checkbox"/> | 10 Employed           | <input type="checkbox"/> | 20 Unemployed and seeking employment in Occupational Therapy     |
| <input type="checkbox"/> | 11 Employed, on leave | <input type="checkbox"/> | 30 Unemployed and not seeking employment in Occupational Therapy |

Recently been hired as an Occupational Therapist in PEI      Proposed Start Date \_\_\_\_\_

Seeking Employment in Prince Edward Island. Provide business information and employment profile when employed in PEI.  
 I understand that it is my responsibility to notify the College of my employment and provide business contact information.

Initial Here

## New Registrant Application Form

This question needs to be answered by ALL categories of registrants.

### Primary Employment Information in PEI Please provide contact information for specific worksite in PEI

Employer Name (Health Authority or Business Name if self-employed) \_\_\_\_\_ Worksite or Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Postal Code reflects site of practice  Yes  No

### Secondary Employment Information in PEI Please provide contact information for specific worksite in PEI

Employer Name (Health Authority or Business Name if self-employed) \_\_\_\_\_ Worksite or Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_

Postal Code reflects site of practice Yes No

### Third Employment Information in PEI Please provide contact information for specific worksite in PEI

Employer Name (Health Authority or Business Name if self-employed) \_\_\_\_\_ Worksite or Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Postal Code reflects site of practice  Yes  No

### Employment Category (indicate only one for each employment)

Primary    
 Secondary    
 Third    
 10 Permanent    20 Temporary    30 Casual    40 Self-Employed

### Full/Part-Time Status (indicate one for each employment including the average weekly hours of work)

Primary  @ \_\_\_\_\_ wk   
 Secondary  @ \_\_\_\_\_ wk   
 Third  @ \_\_\_\_\_ wk   
 10 Full-Time @ # hrs per week    20 Part-Time @ # hrs per week

### Position (indicate only one for each employment)

Primary    
 Secondary    
 Third    
 10 Manager    30 Direct Service Provider    50 Researcher  
 20 Professional Leader/Coordinator    40 Educator    60 Other

### Employment Type (indicate only one for each employment)

Primary    
 Secondary    
 Third    
 10 General Hospital    80 Group Professional Practice/ Clinic  
 20 Rehabilitation Hospital/Facility    90 Solo Professional Practice/ Clinic  
 30 Mental Health Hospital/Facility    100 Post-Secondary Education Institution  
 40 Residential Care Facility    110 School or School Board  
 50 Assisted Living Residence    120 Assoc./Government/Para-Governmental  
 60 Community Health Centre    130 Industry/Manufacturing/Commercial  
 70 Visiting Agency/Business    140 Other

## New Registrant Application Form

### Area of Practice (indicate only one for each employment)

Primary

Secondary

Third

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**Direct Service-Physical Health**  
**20** Neurological  
**30** Musculoskeletal  
**40** Cardiovascular/Respiratory  
**50** Digestive/Metabolic/Endocrine  
**60** General Physical Health

**Additional Areas of Direct Service**  
**10** Mental Health  
**70** Vocational Rehabilitation  
**80** Palliative Care  
**90** Health Promotion & Wellness  
**100** Other Areas of Direct Service Provision

**Additional Areas of Client Management**  
**120** Client Service Management  
**130** Medical/Legal  
**Research**  
**150** Research

**Education**  
**140** Teaching  
**Administration**  
**110** Service Administration  
**160** Other Areas of Practice

### Client Age Range (indicate only one for each employment)

Primary

Secondary

Third

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**10** Preschool Age (0-4)  
**20** School Age (5-17)  
**21** Mixed Paediatrics (0-17)

**30** Adults (18-64)  
**40** Seniors (65+)  
**41** Mixed Adults (18-65+)

**44** All Ages  
**50** Other Client Age Range

### Funding Source (indicate only one for each employment)

Primary

Secondary

Third

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**10** Public/Government  
**20** Private Sector/Individual Client

**30** Public/Private Mix  
**40** Other funding source

**45** Insurance Industry  
**55** Other Insurance

### Professional Liability Insurance

Provide all the information requested below. You must provide a copy of your insurance certificate.

Plan held through  CAOT  Other Insurance Expiry Date \_\_\_\_\_ Certificate Number \_\_\_\_\_

I understand it is my responsibility to maintain professional liability insurance coverage throughout my registration and I am insured for practice in all public and private places of employment.

Initial Here

### Professional Registration

Are you or have you ever been registered/licenced to practice as an occupational therapist in other provinces/states/countries  Yes  No

If yes, provide the information below for EACH registration or license. Attach a separate sheet if additional space is required.

Note: Authorization for Release of Information/Registration in Good Standing Form(s) must be completed by each Regulatory Authority.

Regulatory Body	Prov/State/Country	License/Registration No.	Expiry Date

### OT Practice History

Country where you *first* practiced OT \_\_\_\_\_

Province/territory/state where you *first* practiced OT \_\_\_\_\_

Year you *first* practiced OT \_\_\_\_\_

## New Registrant Application Form

Province/territory/state outside of PEI where you practiced OT most recently \_\_\_\_\_

Most recent year of practice outside of PEI \_\_\_\_\_

### Registration in Other Professions

Are you or have you ever been registered/licensed to practice in another regulated profession in Prince Edward Island/elsewhere  Yes  No

If yes, name the profession(s) \_\_\_\_\_

Provide the information below for EACH registration or license. Attach a separate sheet if additional space is required.

Regulatory Body	Prov/State/Country	Licence/Registration No.	Expiry Date
_____	_____	_____	_____

### Previous History and Conduct

If you answer YES to any of the following questions, please provide full details on a separate page and enclose with your application.

Have you ever been refused registration in an occupational therapy regulatory body?.....  Yes  No

Have you ever had a finding of, or are you currently facing a proceeding for professional misconduct, incompetence, incapacity or similar issue as an OT in PEI or another jurisdiction? (if renewing on PEI, since May 1<sup>st</sup> of previous registration year) .....  Yes  No

Have you ever been the subject of a criminal investigation or criminal proceeding or, have you pleaded guilty or been convicted of a criminal offence?....  Yes  No

Is there anything else in your previous conduct that would afford reasonable grounds for the belief that you lack the knowledge, skill or judgment to practice safely, competently and ethically?.....  Yes  No

### Information Collection and Privacy

**Consent to release my email address** for the purpose of recruitment to research studies. By selecting Yes, I have authorized PEICOT to release my email address to Canadian-based researchers who are conducting research relevant to the practice of occupational therapy practice in Canada and have made a specific request to the College outlining the purpose of the research and indicated that it has received ethics approval by a recognized review board. Consenting to the release of your email **does not** imply consent to participate in the research.

Yes  No

Information collected on this form relates to the mandate, operations and activities of the College as designated under the Regulated Health Professions Act for the purpose of regulating the practice of occupational therapy in Prince Edward Island. The College is a public body and promotes protection of privacy of personal information in a manner consistent with provincial legislation. The PEICOT provides information for national and provincial reporting for the purpose of health human resource planning.

### Private Practice List

We are sometimes asked for a list of registered therapists who wish to do private work. Would you like to be included on this list?  Yes  No

If you would like to have an area of specialty noted, provide brief details:

## Declaration

Initial  
Here

I understand that it is my responsibility to promptly notify the College of **ANY** changes to my name, home address, business address, home phone number, business phone number as well as any changes in my employment.

I verify that all statements contained in this application are accurate. I understand that a false or misleading statement may result in a review of my registration or may be cause for revocation of any registration granted to me.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Name of Witness (please print) \_\_\_\_\_

## Fees

Make cheque or money order payable to PEICOT. A fee is charged for cheques returned indicating Not Sufficient Funds (NSF).

Please see Schedule of Fees for listing of relevant fees.

**Registration Fees:** Initial registration will include the application fee.

**Payment:** Make cheques or money orders payable to PEICOT.

**Reminder:** Check your application carefully. Incomplete applications or applications with missing documentation will delay processing for registration. It is your responsibility to ensure your application is complete.

### Return the Registration Application Forms to:

Heather Cutcliffe,  
139 Cutcliffe Road,  
Borden-Carleton, PE  
COB 1X0

Questions? Call (902) 626-8323

Email [hkcutcliffe@gmail.com](mailto:hkcutcliffe@gmail.com)

### For Office Use Only

Date Received \_\_\_\_\_ Fees  Cheque  Money Order

Application Fees: \_\_\_\_\_ Annual Registration Fee: \_\_\_\_\_

February 2018