As the therapist named below, I am providing/proposing to provide therapy or counselling to the patient named below who is applying for funding for therapy and/or counselling.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Therapist Information** | | | | | | |
| First Name of Therapist |  | | | | | |
| Last Name of Therapist |  | | | | | |
| Pronoun |  | | | | | |
| Work Address |  | Suite | | |  | |
| City/Town |  | | | | | |
| Province/State/Country |  | Postal Code | | | |  |
| Phone Number |  | | | | | |
| Email Address |  | | | | | |
| Are you a member of a regulated health profession? Yes  No  *If YES, please identify below the regulatory authority of which you are a member and the year of membership* | | | | | | |
| Regulatory Authority |  | | | | | |
| Year of Membership |  | | | | | |
| **Patient Information** | | | | | | |
| First Name of Patient |  | | | | | |
| Last Name of Patient |  | | | | | |
| Pronoun |  | | | | | |
| Home Address |  | | Suite |  | | |
| City/Town |  | | | | | |
| Province |  | | Postal Code |  | | |
| Phone Number |  | | | | | |
| Email Address |  | | | | | |
| **Therapist/Counsellor Confirmation** | | | | | | |
| **I confirm that:**   1. I do not have a family or personal relationship with the patient or any other  potential conflict of interest. 2. I understand that funding may only be used to pay for therapy or counselling. 3. I understand that the maximum amount of funding payable to any therapist or counsellor approved under this or any other application to the College of Physiotherapists of Ontario is the amount that the Ontario Health Insurance Plan (OHIP) would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist, not to exceed $17,370. 4. I understand that the funding would be used by the patient at their discretion over the next five years. 5. To my knowledge, OHIP or another private insurer is not covering the costs associated with the therapy or counselling I provide/propose to provide to the patient. 6. I have not at any time or in any jurisdiction been found guilty of professional  misconduct of a sexual nature. 7. I have never been found liable, criminally or civilly, for an act of a sexual nature. 8. I undertake to keep confidential all information obtained through the application for funding process, including if funding is granted, the fact that funding has been granted, and to refrain from using that information for any other purpose. 9. I understand that there will be no payment made to me by the College of Physiotherapists of Ontario for late or missed appointments. 10. I agree to send my invoices for the services provided to the College of Physiotherapists of Ontario directly and understand that the College will pay me directly. 11. I understand that the College may verify the service dates with the patient.   **I confirm the eleven statements listed above and the information provided in this form.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Signature Date* | | | | | | |

**Completed applications should be emailed to** [committeesupport@collegept.org](mailto:committeesupport@collegept.org) **or mailed to:**

Patient Relations Committee

College of Physiotherapists of Ontario

375 University Avenue, Suite 800 Toronto, ON M5G 2J5

**Questions?** If you have further questions, please contact the Deputy Registrar at   
1-800-583-5885 or 416-591-3828 extension 225 or email [committeesupport@collegept.org](mailto:committeesupport@collegept.org).   
To learn more about the [Patient Relations Program](https://www.collegept.org/patient-relations-program) visit the College website [www.collegept.org](http://www.collegept.org).