Form B: Therapist/Counsellor Information

To be completed by the Therapist/Counsellor

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

This form is to be completed by the Applicant's chosen Therapist/Counsellor and is required to ensure funding is provided in accordance with the *Health Professions Procedural Code* under the *Regulated Health Professions Act*, 1991. This form must be submitted together with Form A before the Client Relations Committee can consider an application for funding eligibility.

Applicant Information			
First Name:		Last Name:	
Address:			
City:	Province:	Postal Code:	Country:
Telephone: Fax:		Email:	

Therapist/Counsellor Information			
First Name:		Last Name:	
Address:			
City:	Province:	Postal Code:	Country:
Telephone: Fax:		Email:	

Hourly Rate: _____

Therapist's/Counsellor's Training & Experience:

Are you a regulated health professional?

◯ Yes (please provide College name below) ◯ No

Name of College: _____

Please attach your curriculum vitae to this form.

Therapist's/Counsellor's Declaration

1. I confirm that I will provide therapy/counselling to the Applicant, who is applying for, or has been awarded, funding for therapy/counselling relating to sexual abuse under the program established by the College of Midwives of Ontario.
2. I do not have any familial relationship to the applicant or any other potential conflict of interest.
3. I have not at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature.
4. I have never been found liable, criminally or civilly, for an act of a sexual nature.
5. I have explained my training and experience to the Applicant. If I am not a regulated health professional, I have explained to the Applicant that I would not be subject to professional discipline by a regulatory body.
6. I have attached to this form, my curriculum vitae, which accurately details my training and experience.
7. I understand that funding may only be used to pay for the therapy or counselling for the sexual abuse that made the Applicant eligible for the funding and shall not be applied directly or indirectly for any other purpose.
8. I understand that the maximum amount of funding payable to any therapist or counsellor approved under this program is the amount that that the Ontario Health Insurance Plan (OHIP) would pay for 200 half hour sessions of individual out-patient psychotherapy with a psychiatrist.
9. To my knowledge, neither OHIP nor any public/private insurer is required to pay for the therapy or counselling I provide or am proposing to provide to the Applicant.
10. I understand that there will be no payment from the College of Midwives of Ontario for any late or missed appointments.
11. I undertake to keep confidential all information obtained through the application funding process, including, if funding is granted, the fact that funding has been granted and the reasons given by the Client Relations Committee for granting the funding, and to refrain from using that funding for any other purpose.

Signature of Therapist/Counsellor: _____ Date: _____

Once you have completed this form, please return to the College of Midwives of Ontario via one of the methods listed below:

Mail:
Attn: Professional Conduct Department
College of Midwives of Ontario
21 St. Clair Avenue East, Suite 303
Toronto, ON M4T 1L9

E-mail:
conduct@cmo.on.ca

If you have any questions, please e-mail conduct@cmo.on.ca or call 416-640-2252 x.224.