Saskatchewan Society of Occupational Therapists

P.O. Box 9089, Saskatoon, Saskatchewan S7K 7E7 • Telephone (306) 956-7768

Application for Membership Registration

September, 2010

This registration form must be completed in full. Please ensure that you use appropriate codes where an (*) is present. **All appropriate codes are provided on pages 4 and 5.**

YOU ARE REQUIRED TO NOTIFY THE REGISTRAR OF ANY CHANGES OR IT WILL AFFECT YOUR STANDING.

PERSONAL DATA:

Name: Mr. Mrs. Ms. Miss _____ (Last) _____ (First) _____ (Maiden (Please include confirmation of change of name))

If you were employed or educated under a different name, please list: _____

Home Address: _____ (City) (Province) (Country) (Postal Code)

Home: Phone Number: (____)_____ Fax: (____)_____ e-mail: _____

Business: Ph. Number: (____)_____ Fax: (____)_____ e-mail: _____

Date of Birth: _____ (d / m/ y) Gender: _____ *Employment Status: _____

Age Category: □ 20-24 □ 25-29 □ 30-34 □ 35-39 □ 40-44 □ 45-49 □ 50-54 □ 55-59 □ 60+

MEMBERSHIP DATA:

Membership Category:

□ Practicing □ Temporary (3 month term) □ Restricted License (1 2 3) □ Life □ Student □ Non-Practicing

Have you ever been a previous member or student member of SSOT? _____

Fees submitted (Please refer to enclosed Fee Schedule): _____ Cheque # _____

POST-SECONDARY EDUCATION

1. Basic Education Institution attended (for OT degree if applicable)

Name _____ *ESIS Code _____

Address _____

City _____ Province _____ Country _____ Postal Code _____

Year of Graduation _____ *Degree or Diploma Attained _____

2. Post-Basic Education Institution attended 1 (for OT degree if applicable)

Name _____ *ESIS Code _____

Address _____

City _____ Province _____ Country _____ Postal Code _____

Year of Graduation _____ *Degree or Diploma Attained _____

3. Post-Basic Education Institution attended 2 (for OT degree if applicable)

Name _____ *ESIS Code _____

Address _____

City _____ Province _____ Country _____ Postal Code _____

Year of Graduation _____ *Degree or Diploma Attained _____

4. Post-Basic Education Institution attended 3 (for OT degree if applicable)

Name _____ *ESIS Code _____

Address _____

City _____ Province _____ Country _____ Postal Code _____

Year of Graduation _____ *Degree or Diploma Attained _____

POST-SECONDARY EDUCATION (continued)

5. Other Education Institution attended 1

Name_____ *ESIS Code_____

Address_____

City_____ Province_____ Country_____ Postal Code_____

Year of Graduation_____ *Degree or Diploma Attained_____ *Field of Study_____

6. Other Education Institution attended 2

Name_____ *ESIS Code_____

Address_____

City_____ Province_____ Country_____ Postal Code_____

Year of Graduation_____ *Degree or Diploma Attained_____ *Field of Study_____

Do you currently hold a membership with CAOT?

_____

Do you currently hold a membership with any other professional association?

_____

List employment history for the **last five years**. Within each year, indicate dates of employment, title/position, area of service (e.g. neurology, psychiatry, etc...), employer, hours/week, all sites of employment and total hours of employment as an occupational therapist.

***Ensure this form is completed in full**

EMPLOYMENT HISTORY

Dates From	To	Title & Area	Employer	Hours /Week	Total Hours for year
01/03/2010	Present				
01/03/2009	28/02/2010				
01/03/2008	28/02/2009				
01/03/2007	29/02/2008				
01/03/2006	28/02/2007				

EMPLOYER DATA: (For Volunteer Work, please provide contact person, organization name and address below)

EMPLOYER PROFILE – PRIMARY EMPLOYER

Employer:_____ *Employer Type_____

Employer Address_____
City Prov Country Postal Code

Immediate Manager/Supervisor:_____ Phone: (____)_____ Fax:(____)_____

E-mail: _____ Saskatchewan Health District (if applicable):_____

FACILITY NAME:_____ *Postal Code same as Service Delivery Site (Yes / No / NA)

Address:_____
City Prov Country Postal Code

Phone No.: (____) _____ **F**ax No.: (____) _____

E-mail:_____ Proposed Starting Date:_____

EMPLOYER PROFILE – SECONDARY EMPLOYER

Employer:_____ *Employer Type_____

Employer Address_____
City Prov Country Postal Code

Immediate Manager/Supervisor:_____ Contact Phone: (____)_____ Fax:(____)_____

E-mail: _____ Saskatchewan Health District (if applicable):_____

FACILITY NAME:_____ *Postal Code same as Service Delivery Site (Yes / No / NA)

Address:_____
City Prov Country Postal Code

Phone No.: (____) _____ **F**ax No.: (____) _____

E-mail:_____ Proposed Starting Date:_____

EMPLOYER PROFILE – OTHER EMPLOYER

Employer:_____ *Employer Type_____

Employer Address_____
City Prov Country Postal Code

Immediate Manager/Supervisor:_____ Contact Phone: (____)_____ Fax:(____)_____

E-mail: _____ Saskatchewan Health District (if applicable):_____

FACILITY NAME:_____ *Postal Code same as Service Delivery Site (Yes / No / NA)

Address:_____
City Prov Country Postal Code

Phone No.: (____) _____ **F**ax No.: (____) _____

E-mail:_____ Proposed Starting Date:_____

VOLUNTEER WORK: _____

PROPER CODES

The following identify all the appropriate code entries for fields marked with an (*):

Employment Status

Status Code	Employment Status Description
10	Employed in Occupational Therapy
11	Employed, On Leave
20	Unemployed and Seeking Employment in Occupational Therapy
30	Unemployed and Not Seeking Employment in Occupational Therapy

Educational Institutions ESIS Codes

ESIS Code	Post-Secondary Institution
59001000	University of British Columbia – Parent Institution
48001000	University of Alberta – Parent Institution
46005000	University of Manitoba – Parent Institution
35015000	University of Toronto – Parent Institution
35018000	University of Western Ontario – Parent Institution
35007000	McMaster University – Parent Institution
35011000	Queens University – Parent Institution
35010000	University of Ottawa – Parent Institution
24003000	Université de Montréal – Parent Institution
24002000	McGill University
24005000	Université Laval
12004000	Dalhousie University
99999998	Not Applicable

Degrees or Diplomas Attained

Diploma Code	Degree or Diploma Type
10	Diploma
20	Baccalaureate
30	Master's (only for non-OT related study)
31	Professional Master's (entry level degree)
32	Research Master's
40	Doctorate
98	Not Applicable

Fields of Study

Field Code	Field Name
010	General Rehabilitation Science
020	Health Administration/Management
030	Public Administration
040	Public Health
050	Kinesiology and Exercise Science
060	Gerontology
070	Psychology
080	Health Professions and Related Clinical Sciences
090	Biological and Biomedical Sciences and Physical Sciences
100	Social Sciences, Arts and Humanities
110	Education
120	Law
130	Business, Management, Marketing and Related
140	Other Field of Study
998	Not Applicable

Employer Types

Employer Code	Employer Description
010	General Hospital
020	Rehabilitation Hospital/Facility
030	Mental Health Hospital/Facility
040	Residential Care Facility
050	Assisted Living Residence
060	Community Health Centre
070	Visiting Agency/Business
080	Group Professional Practice/Clinic
090	Solo Professional Practice/Clinic
100	Post-Secondary Educational Institution
110	School or School Board
120	Association/Government/Para-Governmental
130	Industry, Manufacturing and Commercial
140	Other
998	Not Applicable

Postal Code Same as Service Delivery Site

Yes – **Postal code reflects a site where service is delivered.**

No – **Postal code does <u>not</u> reflect a site where service is delivered**. The postal code provided refers to an employer or business office that is different than the site where service is delivered.

PRACTICE PROFILE – PRIMARY PRACTICE

Job Title_____ **Province**_____
Hours _____ hours per week **Country** _____

STATUS: CATEGORY – Must check ONE only.
.....Permanent .....Temporary .....Casual .....Self Employed
.....Not Applicable

STATUS: HOURS – Must check ONE only.
.....Full Time .....Part Time .....Not Applicable

ROLE: Please check the category that best represent the MAIN component of your work
.....Manager .....Professional Leader/Coordinator .....Direct Service Provider .....Educator
.....Researcher .....Other(specify) _____
.....Not Applicable

SYSTEM IN WHICH YOU WORK: Please check the ONE that BEST describes the area of the area of practice
.....Mental Health .....Neurological System ..... Musculoskeletal System
.....Cardiovascular and Respiratory System ..... Digestive/Metabolic/Endocrine System
.....General Physical Health ..... Vocational Rehabilitation .....Palliative Care
.....Client Service Management .....Medical/Legal Related Client Service Management
.....Service Administrator .....Teaching ..... Other Areas of Direct Service(specify) _____
.....Health Promotion & Wellness .....Research
.....Other(specify)_____
.....Not Applicable

FUNDING SOURCES FOR THIS POSITION: Please check the major source of funding for this position (Must check ONE only)
.....Public/Government .....Private Sector or Individual Client(s)
.....Public/Private Mix ..... Other (Specify) _____
.....Not Applicable

CLIENT AGE RANGE: Please Check the age category that BEST represents the MAJORITY of your clients (Must check ONE only)
.....Preschool Age ..... School Age ..... Mixed Pediatrics ..... Adults ..... Seniors
..... Mixed Adults ..... All Ages ..... Not Applicable ..... Other

PRACTICE PROFILE – SECONDARY PRACTICE

Job Title _____ **Province**_____
Hours _____ hours per week **Country** _____

STATUS: CATEGORY – Must check ONE only.
.....Permanent .....Temporary .....Casual .....Self Employed
.....Not Applicable

STATUS: HOURS – Must check ONE only.
.....Full Time .....Part Time .....Not Collected .....Not Applicable

ROLE: Please check the category that best represent the MAIN component of your work
.....Manager .....Professional Leader/Coordinator .....Direct Service Provider .....Educator
.....Researcher .....Other(specify) _____
.....Not Applicable

SYSTEM IN WHICH YOU WORK: Please check the ONE that BEST describes the area of the area of practice
.....Mental Health .....Neurological System ..... Musculoskeletal System
.....Cardiovascular and Respiratory System ..... Digestive/Metabolic/Endocrine System
.....General Physical Health ..... Vocational Rehabilitation .....Palliative Care
.....Client Service Management .....Medical/Legal Related Client Service Management
.....Service Administrator .....Teaching ..... Other Areas of Direct Service(specify) _____
.....Health Promotion & Wellness .....Research
.....Other(specify)_____
.....Not Applicable

FUNDING SOURCES FOR THIS POSITION: Please check the major source of funding for this position (Must check ONE only)
.....Public/Government .....Private Sector or Individual Client(s)
.....Public/Private Mix .....Other (Specify) _____
.....Not Applicable

CLIENT AGE RANGE: Please Check the age category that BEST represents the MAJORITY of your clients (Must check ONE only)
.....Preschool Age ..... School Age ..... Mixed Pediatrics ..... Adults ..... Seniors
..... Mixed Adults ..... All Ages ..... Not Applicable ..... Other

PRACTICE PROFILE – OTHER PRACTICE

Job Title _____ **Province**_____
Hours _____ hours per week **Country** _____

STATUS: CATEGORY – Must check ONE only.
.....Permanent .....Temporary .....Casual .....Self Employed
.....Not Applicable

STATUS: HOURS – Must check ONE only.
.....Full Time .....Part Time .....Not Collected .....Not Applicable

ROLE: Please check the category that best represent the MAIN component of your work
.....Manager .....Professional Leader/Coordinator .....Direct Service Provider .....Educator
.....Researcher .....Other(specify) _____
.....Not Applicable

SYSTEM IN WHICH YOU WORK: Please check the ONE that BEST describes the area of the area of practice
.....Mental Health .....Neurological System ..... Musculoskeletal System
.....Cardiovascular and Respiratory System ..... Digestive/Metabolic/Endocrine System
.....General Physical Health ..... Vocational Rehabilitation .....Palliative Care
.....Client Service Management .....Medical/Legal Related Client Service Management
.....Service Administrator .....Teaching ..... Other Areas of Direct Service(specify) _____
.....Health Promotion & Wellness .....Research
.....Other(specify)_____
.....Not Applicable

FUNDING SOURCES FOR THIS POSITION: Please check the major source of funding for this position (Must check ONE only)
.....Public/Government .....Private Sector or Individual Client(s)
.....Public/Private Mix .....Other (Specify) _____
.....Not Applicable

CLIENT AGE RANGE: Please Check the age category that BEST represents the MAJORITY of your clients (Must check ONE only)
.....Preschool Age ..... School Age ..... Mixed Pediatrics ..... Adults ..... Seniors
..... Mixed Adults ..... All Ages ..... Not Applicable ..... Other

PRACTICE HOURS

Individuals who have been educated as occupational therapists are considered to be:

Practicing if they are involved in activities such as:

A. Performing client assessment, planning, treatment and follow-up, including instruction and supervision of clients, family, support personnel, and caregivers and/or
B. Administration, research, education, consultation in a position where the skills and education of an occupational therapist are utilized, and constitute the basis for practice.

Non-practicing if they are involved in activities in Saskatchewan* for which the qualification of an occupational therapist or a health care professional are not required.
Individuals who wish to apply for non-practicing status should indicate clearly why their activities would fall into the non-practicing category. Individuals should be aware that under this category they will not be accumulating practice hours and they may not hold themselves out to be an occupational therapist.

Notes regarding practice hours:

1. Only actual worked hours are counted toward the practice hours required to maintain a Practicing License. *To maintain eligibility as a practicing member, an occupational therapist must: work in activities requiring the skills of an occupational therapist as approved by council, for at least 1,000 hours in the five-year period or 600 hours in the three year period immediately preceding the date of application for the year in which licensure is sought (*Bylaw X111 Sec 3 1(a)*.* Any type of leave (vacation, leave of absence, maternity leave, illness or disability) cannot be included as practice hours.

2. Practice hours may be a combination of paid, volunteer and education as long as they meet the definition of "practicing". Volunteer and/or education hours may comprise up to 50% of practice hours in a five year period. If therapists have any questions as to whether the hours they intend to claim as practice hours fall within the definition of practicing, they should consult with the SSOT Registrar for guidance.

3. Positions with a different job title, other than OT, but requiring that the incumbent be a health care professional would mean that the person was "practicing" and would therefore count the hours as practice hours.

4. Verification of hours may be requested by the Registrar/Council at any time.

5. The Credentials Committee may at any time review an individual's reported practice hours and decide whether the hours constitute Occupational Therapy practice.

6. If the applicant is not satisfied with the findings of the Credentials Committee, they may appeal to Council.

*Therapists practicing only outside of Saskatchewan are entitled to maintain a non-practicing membership in SSOT.

ADDITIONAL INFORMATION

1. Do you wish to have your name included on a membership list when it is requested by outside agencies (i.e. physicians, human resources, health districts, physiotherapists, etc.)? **Yes** **No**

2. Do you wish to have your name, work address and phone number included on a membership list distributed to SSOT members? **Yes** **No**

3. Do you wish to have your name included on the list of Private Practice OT's that is released to the public? **Yes** **No**

Please indicate the practice areas you would like included on the list:

_____

Please indicate the contact information you would like on the list if it is different from your primary work information:

_____

4. Are you willing to be a mentor to a new member of SSOT? **Yes** **No**

5. For regular SSOT e-mails do you prefer: □ Work Address or □ Home Address?

6. Do you wish to volunteer in SSOT activities (e.g. committees, public relations, council)? **Yes** **No**

List areas of interest:

_____

_____

7. In the previous year, have you been previously registered/licensed to practice as an OT in any other province/country? **Yes** **No**

If so, where?_____

8. Are you currently registered/licensed to practice as an OT in any other province/country? **Yes** **No**

If so, list the current provinces/countries of registration? _____

_____

_____

ADDITIONAL INFORMATION (continued)

9. Have you been refused registration in any OT regulatory body? **Yes** **No**

10. Have you had a find of, or are currently facing a proceeding for, professional misconduct, incompetence or incapacity in any jurisdiction? **Yes** **No**

11. Have you been found guilty of a criminal offense or an offense related to the regulation of practice of OT? **Yes** **No**

12. Were you a recipient of a Saskatchewan Government Bursary? **Yes** **No**
If YES, for what duration? _____

13. Have you ever been suspended, disqualified, censured, reprimanded or had disciplinary action instituted against you as a member of the profession? **Yes** **No**

14. Have you ever been denied any membership, license or permit by any profession or governmental authority, the procurement of which required proof of good moral character? **Yes** **No**

15. Have you ever been suspended or expelled from any post-secondary educational institution? **Yes** **No**

16. Do you currently have 5 million liability/malpractice insurance? **Yes** **No**

17. Have you successfully completed the CAOT National Certification examination? **Yes** **No**

18. Are you an approved Worker's Compensation Board (WCB) provider? **Yes** **No**

Declaration statement regarding application of standards of practice

Declaration:

I, the undersigned, am aware that SSOT has formally adopted the Essential Competencies of Practice for Occupational Therapists in Canada – 2nd Edition as a document which contains established standards of competency for its members. I further understand that it is my professional responsibility to use these standards as a guide in my work as an occupational therapist on an ongoing basis.

_____	_____	_____
Signature of member	License number	Date

DECLARATION

I am aware that SSOT has formally adopted the Essential Competencies of Practice for Occupational Therapists in Canada – 2nd Edition as its definition of the standards of competency for its members and I have incorporated them into my practice of Occupational Therapy.

I hereby certify that the statements made by me in this application are complete and correct to the best of my knowledge and belief. I understand that a false or misleading statement may disqualify me from registration or may cause from revocation or any registration which may be granted me.

Signature_____ Date_____

ADMINISTRATION USE ONLY

Date Application Received: _____ Date Membership Approved: _____ Verbal Approval Given ___:___ / /

Date Fees received: _____ Membership No: _____

Date Notice Sent to Employer: _____ Registrar's Signature: _____

Please review the limitations to occupational therapy practice in Saskatchewan which are listed on www.ssot.sk.ca under information for members.