



OSOT MEMBERSHIP ELIGIBILITY CRITERIA

1. You are eligible for Active Membership in OSOT if:
 - a. You live and/or work in the province of Ontario **and**
 - b. You are employed as an occupational therapist in Ontario and you are registered with the College of Occupational Therapists of Ontario **or**
 - c. You are a graduate occupational therapist enrolled in full time graduate studies **or**
 - d. You are not currently practising as an occupational therapist and you have graduated from a WFOT approved educational program and have successfully completed 1,000 hours of clinical fieldwork or can provide evidence of full membership in the professional association of the country in which you were educated.
2. If you do not meet the eligibility criteria above but are interested in associating with OSOT, you may apply for Associate Member status.
3. Occupational Therapy students should contact the OSOT office for **complimentary** membership registration materials or visit www.osot.on.ca

1. Registrant Information

First Name: _____ Last Name: _____ Initial: _____

Preferred Mailing Address: Residence Primary Employment

Residence Address:

Primary Employment:

City/Town: _____

City/Town: _____

Province: _____ Postal Code: _____

Province: _____ Postal Code: _____

Telephone #: _____

Telephone #: _____

Preferred Email: _____

Fax: _____

Birth Date: _____ (mm/dd/yy)

Do you hold a Secondary Employment Position: Yes No

Gender: Male Female

Language(s) Spoken English French

Other Language(s): _____

2. Eligibility Credentials

a) Academic Qualifications: Check all that apply:

In Occupational Therapy: Certificate/Diploma Clinical Master's Bachelor Doctorate Master's Date Original Degree Obtained: _____

School/Program: _____ Country: _____

In Other Areas: Certificate/Diploma Bachelor Master's Doctorate Obtained Pursuing Date Obtained: _____

Field of Study: _____ School/Program: _____ Country: _____

b) College of Occupational Therapists of Ontario Registration # (If practising in Ontario): _____

c) If you are not practising and are not registered with the College of Occupational Therapists of Ontario, please enclose a copy of your diploma or equivalent.

3. OSOT Volunteer Opportunities: I am willing to consider volunteering for OSOT in the following areas:

- Professional Promotion Professional Issues Related to my Practice Focus
 Regional Advocacy in my Community Member Services Advisory Team

4. Are you part of an Interest Group that is not directly affiliated with OSOT: Yes No

Interest Group Name: _____

5. OSOT Membership Categories & Fee Schedule – ***Please note that all fees include applicable taxes***

OSOT HST #: R104002092

<u>Member Category</u>	<u>New Member Discounted Fees ** (50% Savings)</u>	<u>(This form is not for renewals)</u>	
	<u>Fees reflect discount</u>	<u>Membership Fee</u>	
Full Time >800 Hours/Year **	\$112.44 (includes HST)	\$ __ __ __ __ __ __	
Part Time <800 Hours/Year **	\$ 75.71 (includes HST)	\$ __ __ __ __ __ __	
Non Practising **	\$ 57.63 (includes HST)	\$ __ __ __ __ __ __	
Associate **	\$ 55.94 (includes HST)	\$ __ __ __ __ __ __	
<u>New Graduate Options:</u>			
New Graduate Package including Prof. Liability Insurance	\$116.98 (includes HST)	\$ __ __ __ __ __ __	
New Graduate Membership only	\$ 59.89 (includes HST)	\$ __ __ __ __ __ __	
<u>Insurance Options:</u>		<u>Insurance Fee(s)</u>	
Professional Liability (Malpractice) Insurance (Includes Sexual Abuse Therapy and Counselling fund required by the College)	\$ 44.69 (includes ins. tax)	\$ __ __ __ __ __ __	
General Liability Insurance *** (Non-Professional related claims – i.e. bodily injury, property damage, libel and slander)			
\$2 million coverage	\$70.70 (includes ins. tax)	\$ __ __ __ __ __ __	
\$5 million coverage - Extended	\$112.32 (includes ins. tax)	\$ __ __ __ __ __ __	
Corporation Coverage ***	\$ 24.84 (includes ins. tax)	\$ __ __ __ __ __ __	
Total Amount Due:		\$ __ __ __ __ __ __ 	

*** General Liability and Corporation coverage can only be purchased along with Professional Liability insurance. Private practitioners should contact **LMS PROLINK at 416-595-7484** for additional competitive coverage for their business.

6. Professional Liability Insurance Applicants

- a) In the past, have you or any of your employees ever been the recipient of any allegations of professional negligence, verbally or in writing?
 Yes No
- b) Are you or any of your employees aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above?
 Yes No

7. Payment Enclosed - Please make cheques payable to OSOT

- Cheque Money Order Visa/MasterCard

Credit Card Number: _____ Expiry Date: _____ Amount Charged: _____

Name on Card: _____ Signature: _____

Please Note: A fee of \$15.00 will be charged on all NSF items. If payment options pose a problem or you are in financial difficulty, please contact the OSOT office to discuss alternatives.

8. Declaration

By signing below I agree to abide by the by-laws of the Ontario Society of Occupational Therapists (available upon request or see our website at www.osot.on.ca) and submit appropriate evidence of eligibility.

Evidence of Eligibility:

- Applicants practising in Ontario must provide College of Occupational Therapists of Ontario registration number. See Page 1, # 2. (b).
- Non-practising applicants must provide a copy of professional diploma or evidence of membership in the national association of country of origin.

In signing this document, I agree to the release of registration information relevant to LMS PROLINK (OSOT Insurance Brokers), Encon Canada (OSOT Insurers) and to Sykes Canada Corporation (OSOT Legal Advisory Services Plan). For details of the OSOT Privacy Policy, please visit www.osot.on.ca

I declare that the above information is correct and have attached copies of all applicable documents.

Signature: _____ Date: _____

Don't forget to complete, sign and return your Data Survey Form with your application. Please note failure to complete required information will result in a membership processing delay. Your form may be returned to you for completion.



Ontario Society of Occupational Therapists

55 Eglinton Ave. E., Suite 210
Toronto, Ontario, M4P 1G8
Tel: (416) 322-3011 or 1-877-676-6768
Fax: (416) 322-6705 Email: osot@osot.on.ca

2011-2012 Member Data Survey Form
October 1, 2011 - September 30, 2012 Membership Year

Name: _____

The Ontario Society of Occupational Therapists maintains a membership database that includes detailed information about members' professional practice and employment. This information is most often used as consolidated data pulls that enable the society to track trends, report statistics to members, government and payors and to develop member services to fit member needs. Information may be individually selected for the purposes of facilitating networking, identifying experts, professional referrals, etc. as per your consent to release information on reverse.

This data is important. Don't forget to complete, sign and return this Data Survey Form with your application. Please note that failure to complete required information will result in a membership processing delay. Your form may be returned to you for completion.

PLEASE SIGN RELEASE ON THE BACK OF THIS PAGE.

A. Employment & Compensation

As a provincial association, it is critical to monitor employment patterns and compensation information to ensure that OSOT's professional advocacy is supported by data. Data also supports OSOT's fee negotiating activity and response to member enquiries regarding compensation trends.

Please note: In an effort to collect as much information as possible we ask that you indicate your **Primary Employment Information in check box column 1** and, **if applicable, your Secondary Employment Information in check box column 2** for all items below, where indicated.

1. Employment Status (Please check **all** that apply)

- | | |
|--|--|
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Employed Contract Position | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Self Employed – Own Practice |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Employed Salaried Position | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Self Employed – Independent Contractor |
- Other:** _____

2. Hours Worked Per Week (paid hours) (Check **all** that apply - Divide between **Primary and Secondary**)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Casual | <input type="checkbox"/> ¹ <input type="checkbox"/> ² 11-15hrs | <input type="checkbox"/> ¹ <input type="checkbox"/> ² 26-34hrs | <input type="checkbox"/> ¹ <input type="checkbox"/> ² 37.5hrs |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² 5-10hrs | <input type="checkbox"/> ¹ <input type="checkbox"/> ² 16-25hrs | <input type="checkbox"/> ¹ <input type="checkbox"/> ² 35hrs | <input type="checkbox"/> ¹ <input type="checkbox"/> ² >37.5hrs |

3. Job Title (Check the title that best describes your position)

- | | | | |
|--|--|--|---------------------|
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Staff Therapist | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Manager/Director | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Private Practitioner | Other: _____ |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Senior Therapist | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Academic Faculty | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Researcher | |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Practice Leader | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Consultant | | |

4. Practice Experience

- New Graduate 1-2 years 3-5 years 6-10 years 11-15 years 16-20 years >20 years

5. Funding for your Position (Check **all** that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Corporate Business | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Provincial Government - Other | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Municipal Government |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Private Individuals | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Insurance - Auto | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Federal Government |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Provincial Government – Health | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Insurance - Extended Health/Disability | <input type="checkbox"/> ¹ <input type="checkbox"/> ² WSIB |

Other Funding: _____

6. Employed Positions: *Please note this information is for statistical purposes only and will not be used or disclosed with any personal identification.*
If Self Employed please **complete question 7.**

a) Hourly Earnings (Calculate gross income per year ÷ hours worked in a year)

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$0-\$19 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$26-\$30 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$36-\$40 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$51-\$60 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² over \$70 per hr |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$20- \$25 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$31-\$35 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$41-\$50 per hr | <input type="checkbox"/> ¹ <input type="checkbox"/> ² \$61-\$70 per hr | |

b) Employee Benefits: Please check **all** that apply.

- | | | | |
|---|---|--|---------------------|
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Extended Health/Dental Coverage | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Education Funding | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Life Insurance | Other: _____ |
| <input type="checkbox"/> ¹ <input type="checkbox"/> ² Disability Insurance | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Education Leave | <input type="checkbox"/> ¹ <input type="checkbox"/> ² Pension | |

c) Union Membership

- I am **not** a Union Member I **am** a Union Member **Union Name:** _____

7. Self Employed: *Please note that this information is for statistical purposes only and will not be used or disclosed with any personal identification.*

a) What is the hourly rate that you charge for your:

OT Services \$ _____ Travel Time \$ _____ Other \$ _____ (specify)

b) What is your approximate hourly net income rate (gross billings – business expenses ÷ # hours worked) \$ _____ ?

B. Professional Practice

Please note, In an effort to collect as much information as possible, we ask that you indicate your **Primary Employment Information in check box column 1** and **if applicable, your Secondary Employment Information in check box column 2** for all items below, where indicated.

1. Key Description(s) of Role: (Please check up to 4 categories that represent the most common components of your work)

- 1 2 Educator Consulting Direct/Indirect Client Contact
Public Relations/Professional Promotion Administration/Management Research

2. Client Ages: (Please identify all clients/populations with whom you work, i.e. within clinical practice, research, teaching)

- 1 2 Neonate School Age Adult All
Pre School Age Adolescent Older Adult (65+)

3. Practice Foci: (Please check up to 4 areas that best describe the foci of your practice) – if N/A please check here

- 1 2 Addiction Issues CVA Learning Disabilities Rheumatology
Amputations Dementia Mood Disorders Oncology
Anxiety Disorders Developmental Disability Multiple Sclerosis Orthopaedics
Autism Spectrum Eating Disorders Muscular Dystrophy Post Traumatic Stress
Burns General Medicine Neonatology Psychoses/Schizophrenia
Cardiology Genetic Disorders Neurological Diseases/ Disorders Repetitive Strain Injury
Cerebral Palsy Gerontology Severe Persistent Mental Disorder
Chronic Pain HIV/AIDS Respiratory Soft Tissue Injury
Spinal Cord Injury
Traumatic Brain Injury

Does this section allow you to adequately describe your Practice Foci? Yes No

Comments/Other:

4. Practice Settings: (Please check up to 4 settings which best describe where you work)

- 1 2 Continuing Care Facility Group Home Post-Secondary Institution Regulatory Body/ Professional Association
Client's Work Site Industry (University) Retail Business
Client's Home Insurance Company Private Health Business School System (Elementary/Secondary)
Community Clinic/Agency Long Term Care Home Professional Services (e.g. Lawyers, Architects)
Correctional Services Mental Health Centre Rehabilitation Centre WSIB Clinic
General Hospital Paediatric Centre Recreational Facility/ Services
Government Post-Secondary Institution (Community College)

Other:

5. Foci of OT Services: (Please select a maximum of 6 areas that best describe the OT services that you provide)

- 1 2 Acupuncture Driver Evaluation/Training Health Promotion/Wellness Program Evaluation / Research
Advocacy/Self Help Equip/Material Sales Consulting Home Support Primary Healthcare
Assessment for Benefits Environmental Access/Adapt. Lobbying/ Advocacy Prosthetics
Assistive Technology Ergonomics Mental Health Services Psychotherapy
Caregiver Support/Education Forensic Medical Legal Return to Work
Case Management Feeding/Swallowing Neuro Developmental Treatment Seating/Mobility
Cog. Behaviour Therapy Fine Motor Intervention Occupational Life Skills Sensory Integration
Community Development Functional Restoration Programs Orthotics Stress Management
Consulting Group Interventions Palliative Care Supportive Counselling
Co-Op Hand Rehabilitation Perceptual/Cognitive Rehab. Vocational Rehabilitation
Crisis/Emergency Service Health Ed./Disease Prevention Program Coordination/Admin

Does this section allow you to adequately describe your Foci of OT Services? Yes No

Comments/Other:

C. Release of Information

By choosing YES, I authorize OSOT to release my personal contact information, in keeping with OSOT policies, for the purposes identified below: OSOT's Privacy Policies are available from the OSOT office or at www.osot.on.ca

1. My name, employer, preferred mailing address to a Third Party for the purposes of receiving the following;

- Yes No
Recruitment/Job Advertisements
Product/Workshop/Conference Advertising
Research/Surveys related to OT

2. My name and business contact information to OSOT members and members of the public for the following purposes;

- Yes No
Private Client Referrals/Consulting
Legal Referrals
Professional Networking
Education/Public Relations
Contact me as a potential mentor
Contact me as a potential supervisor

Yes No
I would like to receive future OSOT Membership Renewal notifications and to complete my registration online.

Signature: Date:

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