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

2018-2019 Member Application Form

October 1, 2018 - September 30, 2019 Membership Year

*(This form is **not** for OSOT Members who are renewing their membership)*

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 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 (please select): ☐ **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/yyyy):		**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 (please select all that apply)

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

School/Program: _____ Country: _____

In other areas: ☐ Certificate/Diploma ☐ Master's ☐ Obtained ☐ Pursuing Date Obtained: _____
☐ Bachelor ☐ Doctorate

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

b) College of Occupational Therapists of Ontario (COTO) Registration # (if practising in Ontario):

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

3. OSOT VOLUNTEER OPPORTUNITIES - I am willing to consider volunteering for OSOT in the following area(s):

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

4. INTEREST GROUPS - Are you part of an Interest Group that is not directly affiliated with OSOT? ☐ **YES** ☐ **NO**

Name of Interest Group:

5. OSOT MEMBERSHIP CATEGORIES & FEE SCHEDULE

OSOT HST #: R104002092

Please select one of the following options:

____ I am a **New Member** – I am joining for the first time or have not been a member in the past 3 years.

____ I am a **Rejoining Member** – I've been a member within the past 3 years.

Please note: This form is not for OSOT Members who are renewing their membership for the 2018-2019 membership year.

	Column 1 ***(New Member)***	**Column 2** ***(Rejoining Member)***	
Member Category	** Fees reflect 50% discount*		**Member Fees - (Please complete)**
Practising	$126.00 (incl. HST) *	$ 251.99 (incl. HST)	$ |____|____|____|____|____|____|
Non-Practising	$ 64.98 (incl. HST) *	$ 129.95 (incl. HST)	$ |____|____|____|____|____|____|
Associate	$ 63.28 (incl. HST) *	$ 126.56 (incl. HST)	$ |____|____|____|____|____|____|
Retired	$ 29.38 (incl. HST)	$ 29.38 (incl. HST)	$ |____|____|____|____|____|____|
New Graduate Options:			
New Graduate Package incl. Professional Liability Insurance		Complimentary	☐
New Graduate Membership only		Complimentary	☐
Insurance Options:			**Insurance Fee(s) - (Please complete)**
Professional Liability Insurance ***(College of Occupational Therapists of Ontario approved)***		$69.00 (tax incl.)	$ |____|____|____|____|____|____|
General Liability Insurance ****** (non-professional related claims – i.e. bodily injury, property damage, libel and slander)			
$2 million coverage		$129.60 (tax incl.)	$ |____|____|____|____|____|____|
$5 million coverage		$189.00 (tax incl.)	$ |____|____|____|____|____|____|
Corporation Coverage **		$31.32 (tax incl.)	$ |____|____|____|____|____|____|
Total Amount Due:			$ |____|____|____|____|____|____|

*** General Liability and Corporation coverage can only be purchased along with Professional Liability insurance. Private practitioners should contact* ***PROLINK*** *at* ***416-595-7484*** *or* ***Toll Free*** *at* ***1-800-663-6828*** *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

☐ Cheque (please make payable to OSOT) ☐ Visa/MasterCard ☐ Money Order

Credit Card Number: _____ Exp. Date: _____ Amt. Charged: _____

Name on Card: _____ Signature: _____

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 and submit appropriate evidence of eligibility. (By-laws are available upon request or see our website at www.osot.on.ca)

Evidence of Eligibility:

1. Applicants practising in Ontario must provide College of Occupational Therapists of Ontario registration number. See Page 1, # 2 (b).
2. 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 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: _____

Do not forget to complete, sign and return your Member Data Survey Form with your application. Please note that failure to complete the 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, ON M4P 1G8
Tel: 416-322-3011 or 1-877-676-6768

2018-2019 Member Data Survey Form

October 1, 2018 - September 30, 2019 Membership Year

Name: _____

The Ontario Society of Occupational Therapists (OSOT) 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 OSOT 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. Do not forget to complete, sign and return this Member Data Survey Form with your application. 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 NEXT PAGE

EMPLOYMENT AND 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)

1 2
☐ ☐ Employed Contract Position
☐ ☐ Employed Salaried Position
☐ ☐ Self Employed – Own Practice
☐ ☐ Self Employed – Independent Contractor

Other: _____

2. Hours Worked Per Week (paid hours) (please check **all** that apply and divide between **Primary** and **Secondary Employment)**

1 2
☐ ☐ Casual
☐ ☐ 5 - 10hrs
☐ ☐ 11 - 15hrs
☐ ☐ 16 - 25hrs
☐ ☐ 26 - 34hrs
☐ ☐ 35hrs
☐ ☐ 37.5hrs
☐ ☐ >37.5hrs

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

1 2
☐ ☐ Staff Therapist
☐ ☐ Senior Therapist
☐ ☐ Practice Leader
☐ ☐ Manager/Director
☐ ☐ Academic Faculty
☐ ☐ Consultant
☐ ☐ Private Practitioner
☐ ☐ Researcher

Other: _____

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 (please check **all** that apply)

1 2
☐ ☐ Corporate Business
☐ ☐ Private Individuals
☐ ☐ Provincial Government – Health
☐ ☐ Provincial Government - Other
☐ ☐ Insurance - Auto
☐ ☐ Insurance - Extended Health/Disability
☐ ☐ Municipal Government
☐ ☐ Federal Government
☐ ☐ 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)

1 2
☐ ☐ $0 - $19 per hr
☐ ☐ $20 - $25 per hr
☐ ☐ $26 - $30 per hr
☐ ☐ $31 - $35 per hr
☐ ☐ $36 - $40 per hr
☐ ☐ $41 - $50 per hr
☐ ☐ $51 - $60 per hr
☐ ☐ $61 - $70 per hr
☐ ☐ over $70 per hr

b) Employee Benefits (please check all that apply)

1 2
☐ ☐ Extended Health/Dental Coverage
☐ ☐ Disability Insurance
☐ ☐ Education Funding
☐ ☐ Education Leave
☐ ☐ Life Insurance
☐ ☐ Pension

Other: _____

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) $ _____

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

3. Practice Areas (please check up to 4 areas that best describe the foci of your practice) **If N/A please check here** ☐

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

Does this section allow you to adequately describe your practice area? ☐ **YES** ☐ **NO**

Comments/Other: _____

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

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

Comments/Other: _____

5. Provision of OT Services (please select a maximum of 6 areas that best describe the OT services that you provide)

1	2		1	2		1	2		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 OT services? ☐ **YES** ☐ **NO**

Comments/Other: _____

C. RELEASE OF INFORMATION

By choosing **YES**, I authorize the Ontario Society of Occupational Therapists (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, email address 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: _____

Do not forget to complete, sign and return your Member 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.