ONTARIO
Council of Drugless Osteopathy

# 2024 Application Form

## Personal Information

First Name | Last Name

Date of Birth (MM/DD/YY) | Gender

Phone Number (Cell) | Phone Number (Other) | Email

Street Address | City | Province | Postal Code

## Osteopathic Educational Background

** Please attach a copy of all transcripts AND diplomas/certificates

Post-Secondary School Name | Location

Name of Program/Degree Earned/Designation Awarded | Type 1 or 2 Program[1]

Total Number of Program Hours | Program Format (In-class, online or blended)

Date Program Started (MM/DD/YY) | Date of Graduation (MM/DD/YY)

[1] Please refer to the WHO Benchmarks for Training in Osteopathy

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## Other Educational Background

** Please provide documentation of all your previous healthcare training.

Institution #1

Post-Secondary School Name | Location

Name of Program/Degree Earned/Designation Awarded | Document Awarded

Total Number of Program Hours | Program Format (In-class, online or blended)

Number of Clinical Rotation Hours | Location

Date Program Started (MM/DD/YY) | Date of Graduation (MM/DD/YY)

Institution #2 (if applicable)

Post-Secondary School Name | Location

Name of Program/Degree Earned/Designation Awarded | Document Awarded

Total Number of Program Hours | Program Format (In-class, online or blended)

Number of Clinical Rotation Hours | Location

Date Program Started (MM/DD/YY) | Date of Graduation (MM/DD/YY)

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## Professional Information

** Make sure to include all practice locations. This section should be completed for each place of practice.

How many hours are you practicing a month on average?

Please list all other modalities and services you provide.

Practice Location #1

Business Name | Position

Business Phone Number | Extension | Fax Number

Email | Website

Street Address | City | Province | Postal Code

Business Owner Name(s)[2]

Practice Setting | Services Provided

[2] Including, but not limited to sole proprietor, partners, franchises, etc.

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Practice Location #2

Business Name | Position

Business Phone Number | Extension | Fax Number

Email | Website

Street Address | City | Province | Postal Code

Business Owner Name(s)[3]

Practice Setting | Services Provided

In-Home Practice (if applicable)

** Only applicable if you provide services in a client's home

Services Provided

Areas Served

**Information to be listed on the website in Member Search**

City/Town | Preferred Business Phone # or Email

[3] Including, but not limited to sole proprietor, partners, franchises, etc.

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## Professional Associations & Memberships

** Include all current regulatory bodies and associations you are a member of, including student memberships.

### Association #1

| Association Name | Registration Number | Status |
|---|---|---|
| Association Phone Number | Fax Number | |
| Email | Website | |
| Issue Date (MM/DD/YY) | Expiry Date (MM/DD/YY) | |

### Association #2

| Association Name | Registration Number | Status |
|---|---|---|
| Association Phone Number | Fax Number | |
| Email | Website | |
| Issue Date (MM/DD/YY) | Expiry Date (MM/DD/YY) | |

Association #3

| Association Name | Registration Number | Status |
|---|---|---|
| Association Phone Number | Fax Number | |
| Email | Website | |
| Issue Date (MM/DD/YY) | Expiry Date (MM/DD/YY) | |

## Professional Liability Insurance

| Carrier | Amount |
|---|---|
| Services Covered | |
| Issue Date (MM/DD/YY) | Expiry Date (MM/DD/YY) |

## Professional Conduct

** If you answer yes to any of the following questions, you must provide further information.

Have you, the applicant, ever had findings of guilt for professional misconduct, incompetence, or incapacity? ◯ Yes ◯ No

Are you, the applicant, currently under investigation for professional misconduct, incompetence, or incapacity? ◯ Yes ◯ No

Have you, the applicant, ever resigned from any regulatory or licensing organization while being the subject of a complaint, investigation, or proceeding with respect to professional misconduct, incompetence, or incapacity? ◯ Yes ◯ No

Have you, the applicant, ever had charges or findings of guilt under certain legislation or for a criminal offence? ◯ Yes ◯ No

Are you, the applicant, currently under investigation for any criminal offences? ◯ Yes ◯ No

## Application Checklist

***Your application will only be processed once the following list is completed and submitted.***

- ☐ Complete and submit your completed application form. If there is not enough space for all of your practice locations, attach them in a separate document.

- ☐ Provide documentation of manual osteopathic training from an institution that meets the World Health Organization's Benchmarks for training in Osteopathy (2010). Acceptable documentation must include diploma AND transcripts.

    - ☐ If you completed a Type 2 program, you must also provide documentation of your previous healthcare training.

- ☐ Submit proof of a minimum of Standard First Aid and CPR (Level C)**.** This certification must be current.

- ☐ Copy of government issued photo identification. Acceptable forms of identification include a driver's license, passport, citizenship card. Provincial health cards are not permissible forms of identification.

- ☐ Proof of professional insurance coverage with a minimum liability of $5 million.

- ☐ Submit a current Criminal Record and Vulnerable Sector Check (must be dated no earlier than 12 months from date of application).

- ☐ Disclose any criminal investigations, criminal convictions or any professional misconduct proceedings/findings against you.

- ☐ I understand that there is a $100 CAD non-refundable application fee and will pay it promptly upon receiving the invoice. Your application will not be processed until we receive the application fee. If your application is approved, the application fee will be credited towards the full membership fee.
  *2024 fee is $450.*

Please only submit your application once the requirements of this checklist have submitted.

## Important Information

### Application Submission

Please submit your application via email to mail@ocdo.ca.

### Payment

Once your application is received, you will receive an emailed invoice for payment.

### Website Listing

Once your application is approved, your name and membership status will be posted on the OCDO website for insurance companies to verify your status.

### Signature & Submission

By signing and/or submitting this document, I _____, confirm that the information submitted in this application is true and correct to the best of my knowledge.

### Please Note

Incomplete applications will not be processed until all required information is submitted. No refunds will be given for cancellation of membership for any reason. OCDO reserves the right to request additional information prior to processing a membership application. OCDO reserves the right to refuse membership to any applicant.

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Signature Date (MM/DD/YY)