COLLEGE OF DENTURISTS OF ONTARIO

Application for Funding for Therapy and Counselling

*To be considered for funding, this form must be completed by the Applicant. Once you have a therapist or counsellor they will be required to complete **Form K2** – Therapist and Counsellor Information.*

The Patient Relations Committee follows the provisions of the Regulated Health Professions Act, 1991 (RHPA) when determining whether an applicant is eligible for funding for therapy and counselling. Completed application forms will be reviewed by the Patient Relations Committee of the College of Denturists of Ontario to determine eligibility for funding for therapy and counselling.

Section 1: Applicant's Information

Salutation: ◯ Ms. ◯ Mrs. ◯ Mr.

Last Name: _____ First Name: _____

Address: _____ Unit/Suite: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Phone: _____

I was sexually abused by _____ while I was their patient.
(Denturist's Name)

This abuse took place in _____.
(city/province)

The time period that this abuse took place was from *(approximate dates)* _____ to _____.

If you know the following information, please provide the date and details:

A complaint was made or a Registrar's Investigation was initiated by College of Denturists on _____(date) alleging that I was sexually abused by the above-named Registered Denturist while I was a patient.

Section 2: Therapist/Counsellor Information

_____ , providing/propose to provide therapy or counselling

[name of therapist or counsellor - please print]

Is this therapist/counsellor a regulated health professional? ☐ Yes ☐ No

If yes, name the College with which the therapist/counsellor is registered: _____

Are the services of this therapist/counsellor covered by OHIP or another insurer? ☐ Yes ☐ No

If yes, please provide details: _____

_____

Have you already had therapy or counselling for this abuse? ☐ Yes ☐ No

If yes, attach all copies of all bills paid/received to date.

If no, expected start date of therapy or counselling: _____

Section 3: Declaration and Signature

By signing this document, I acknowledge and agree to the following:

1. I am hereby applying for funding for therapy or counselling under the program established by the College of Denturists of Ontario pursuant to section 85.7 of the Health Professions Procedural Code of the *Regulated Health Professions Act, 1991*.

2. I understand that a decision by the Patient Relations Committee that I am eligible for funding does not constitute a finding of guilt against the above-named Denturist and shall not be considered by any other committee of the College dealing with them.

3. I agree to allow the College of Denturists of Ontario to contact the above named therapist/counsellor, as necessary to process this application for funding.

Applicant's Signature

Date (mm/dd/yyyy)

Section 4: Form Submission

The completed form can be submitted to the College by one of the following methods:

By Email: **info@denturists-cdo.com**
Subject Line: Funding Application

By Fax: 416-925-6332
Attn: Registrar & CEO

By Mail:
Attn: Registrar & CEO
College of Denturists of Ontario
365 Bloor Street East, Suite 1606
Toronto, ON M4W 3L4