



Form E: Request for Change of Therapist/Counsellor

This form must be completed by the individual to whom funding has been granted by the Client Relations Committee for therapy/counselling. Completed application forms will be reviewed by the Client Relations Committee to determine the suitability of the proposed therapist/counsellor. Form B must be completed by your chosen therapist/counsellor.

Individual Information

Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone _____ Email _____

Therapist/Counsellor Information

Name _____

Address _____

City _____ Province _____ Postal Code _____

Telephone _____ Email _____

Note: Pursuant to s. 85.7(5) of the RHPA:

1. The therapist or counsellor must not be a person to whom you have any family relationship.
2. The therapist or counsellor must not be a person who has at any time or in any jurisdictions been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature.
3. If the therapist or counsellor is not a member of a regulated health profession, you understand that the therapist or counsellor is not subject to professional discipline.

Information About Therapy/Counselling:

Is this therapist/counsellor a regulated health professional?

Yes (please provide College name below) No Don't Know

Name of College: _____

Are the services of this therapist/counsellor covered by OHIP or another private insurer?

Yes No Don't Know

Expected or actual start date of therapy/counselling: _____



Individual's Consent for Disclosure of Information

I hereby authorize (Name of Therapist/Counsellor) _____ to disclose information, including personal health information, to the College of Midwives of Ontario.

I consent to the following information being disclosed:

- Appointment Date Duration Fee

Individual's Declaration

1. I do not have any familial relationship to the therapist or counsellor or any other potential conflict of interest.
2. I understand that if I choose a therapist or a counsellor who is not a regulated professional, the therapist is not subject to professional discipline by a regulatory body.
3. I am aware of the therapist's or counsellor's training and experience.
4. I understand that funding shall only be paid to the therapist or counsellor and that it shall be used for the sole purpose of paying for therapy or counselling for the sexual abuse that made me eligible for the funding.
5. I understand that the maximum amount of funding payable to any therapist or counsellor is the amount that the Ontario Health Insurance Plan (OHIP) would pay for 200 half hour sessions of individual out-patient psychotherapy with a psychiatrist.
6. I will use the other sources of funding for therapy or counselling that are available to me first, such as that available through a private insurer.
7. I understand that there can be no duplicate payment for the same service. To my knowledge, neither OHIP nor any public/private insurer is required to pay for the therapy or counselling I receive from the therapist or counsellor. If at any time, OHIP or a private insurer becomes required to pay for the therapy or counselling, I shall notify the College.
8. I understand that the funding available from the College does not cover late appointments, missed appointments or other expenses incidental to receiving therapy, such as travelling costs.

Signature _____

Date _____

Processing Information

Once you have completed this form, please return to the College of Midwives of Ontario via one of the methods listed below:

E-mail (preferred): conduct@cmo.on.ca

Mail: Attn: Professional Conduct Coordinator, College of Midwives of Ontario
21 St. Clair Avenue East, Suite 303, Toronto, ON M4T 1L9

If you have any questions, please contact us by e-mail at conduct@cmo.on.ca or telephone at 416-640-2252.