



# Request for funding

## Form B – Therapist/counsellor

This form is to be completed by a therapist/counsellor who is treating someone who alleges that they were sexually abused by a Medical Laboratory Technologist (MLT) and are seeking funding for therapy and/or counselling. Information about this process can be found on CMLTO’s Factsheet for funding [here](#).

This form must be submitted with [Form A](#) – Patient form. As part of the therapist/counsellor’s form, they are required to submit a brief statement containing details of their training and experience related to the treatment of victims of sexual abuse, the type of therapy/counseling to be provided, and will also be required to sign a confidentiality agreement. If you have any questions, please contact the CMLTO Professional Conduct department by email at [professionalconduct@cmlto.com](mailto:professionalconduct@cmlto.com) or by telephone at 1-800-323-9672.

1 Therapist/Counsellor’s contact information	
Full name	
Mailing address	
Suite/Apt.	City/Town
Province	Postal code
Telephone	Email
Are you a member of a regulated health profession?	Yes No
If <b>yes</b> , please provide the name of your regulatory body & registration number	
Please provide the details of your training and experience relevant to victims of sexual abuse, and the type of services to be provided to the patient.	
Are your services covered by OHIP or another insurer?	Yes No
Start date for therapy/counselling services	



2

### Patient's contact information

Full name

Street address

Suite/Apt.

City/Town

Province

Postal code

Telephone

Email

3

### Declaration

1. I have read and understand the CMLTO's [Factsheet for therapy or counselling funding](#) which outlines the use of funding under this program and how payments are processed.
2. I confirm that I, the therapist or counsellor, do not have any family relationship to the patient.
3. I confirm that, I have not been found guilty of, nor am I under investigation for, concerns related to incompetence, incapacity, or professional misconduct by a professional regulatory body inside or outside of Ontario.
4. I have not been found by a civil court to have been engaged in professional negligence or malpractice.
5. I have not been charged with an offence under the Criminal Code (Canada) or the Controlled Drug and Substances Act (Canada).
6. I understand that funding is to be used for therapy and counselling related to the alleged abuse only and shall not be applied directly or indirectly for any other purpose.
7. I give consent to the CMLTO to contact me, the therapist/counsellor, for the purpose of processing the patient's request for funding.

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### Therapist/Counsellor's Signature

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Please submit the completed form by email to [professionalconduct@cmlto.com](mailto:professionalconduct@cmlto.com) or by mail to:

**Patient Relations Committee**

College of Medical Laboratory Technologists of Ontario  
Suite 2100 - 25 Adelaide Street East  
Toronto, Ontario M5C 3A1