

MARRT LICENSE/MEMBERSHIP APPLICATION 2010

Applications must be postmarked no later than January 31. Please supply all information requested. Incomplete forms will be returned to applicant for completion. There will be a \$50 administration fee for incomplete or late applications.

Please mail application and cheque to MARRT at Box 2087, Winnipeg, Manitoba R3C 3R4

PERSONAL DEMOGRAPHICS: If your information is unchanged from last year, you may fill in your name and leave the remaining fields blank. If there are any changes, please fill in all information.

1. PERSONAL DEMOGRAPHICS

Title: M _____	Surname: _____	First Name: _____	Initial: _____
Maiden Name (if applicable): _____		Date of Birth: Year _____ Month _____ Day _____	
Permanent Mailing Address: _____			
City / Town _____ Province _____		Postal Code _____	
Telephone _____		Email _____	

2. MUTUAL RECOGNITION AGREEMENT: (normally used when applying from another jurisdiction).

Are you applying under the Mutual Recognition Agreement (MRA)? Yes No If **yes** please select which of the following organizations apply to you.

CARTA (College and Association of Respiratory Therapists of Alberta)

CRTO (College of Respiratory Therapists of Ontario)

CSRT (Canadian Society of Respiratory Therapists)

OPIQ (l'Ordre professionnel des inhalotherapeutes du Quebec)

3. LICENSE / MEMBERSHIP CATEGORY: Please check all applicable boxes

Initial Application Fee (does not apply to current or student members)	\$25	
Active Practicing License	\$155	
Active Practicing Graduate License (year of graduation only)	\$80	
Inactive Membership	\$115	
Associate Membership	\$125	
Student Membership	No Fee	
Replacement (lost or damaged) plastic license card	\$10	

Other than Graduates', applications received after June 30 will be prorated for that license year at 50% of applicable fee.

4. RESPIRATORY THERAPY EDUCATION

Institution: _____	Degree/Diploma/Certificate _____	Year of Graduation _____
Credential Examination Status: Examination Successful	Verification of successful completion of approved examination. Please enter all applicable registry numbers.	
If Examination Unsuccessful: 1 st Attempt Date _____	CSRT registry number _____	
2 nd Attempt Date _____	OPIQ registry number _____	
3 rd Attempt Date _____	NBRC registry number _____	

If registry number is not entered (when available) the application will be returned and the administration fee will be assessed.

5. EMPLOYMENT STATUS

Place of Employment _____				
<table> <tr> <td>Full Time Permanent</td> <td>Full Time Temporary</td> </tr> <tr> <td>Part Time</td> <td>Casual</td> </tr> </table>	Full Time Permanent	Full Time Temporary	Part Time	Casual
Full Time Permanent	Full Time Temporary			
Part Time	Casual			
Have you practiced full time for the last five months Yes No				
If no please complete the work history below: Number of hours worked:				
-in the current license year _____ Employer _____				
-one year prior to current year _____ Employer _____				
-two years prior to current year _____ Employer _____				
-three years prior to current year _____ Employer _____				

“In order to qualify for renewal of registration as an active practicing member, a person shall A: have practiced for at least a total of 720 hours in the four year period immediately preceding the registration year of the association, for which renewal of registration is sought; and B: not be subject to any suspension or revocation of his or her right to practice as a registered respiratory therapist in any jurisdiction.”

6. PROFESSIONAL CONDUCT

I have participated in the MARRT Continuing Competency Program

Yes No

I have been convicted of an offense under the Criminal Code of Controlled Drugs and Substances, or Food and Drug Acts.

Yes No

I have been denied registration by a professional regulatory body.

Yes No

I have had my registration/license revoked, suspended, restricted, or subject to terms and conditions by a regulatory body in this and/or other jurisdictions.

Yes No

I am currently under investigation by a regulatory body in this and/or other jurisdictions.

Yes No

Within the past year I have been made aware of a physical or mental condition, disorder, or addiction to alcohol or drugs that may impair my ability to practice competently and effectively.

Yes No

7. DECLARATION:

I **declare/verify** that to the best of my knowledge that the statements made by me in this application are complete and accurate. I **understand** that non-compliance or misrepresentation of any section may be cause for revocation of my license. I **agree** to notify the MARRT, in writing, within 30 days of any change(s) in the information reported on this application.

Signature of Applicant: _____

Date: _____

FOR OFFICE USE ONLY:

Date Application Received: _____ Monies received: _____

Date Application Approved _____

Registrar's Signature: _____

Type of License/Membership Granted:

AP APG Assoc. I S

Any Conditions Imposed: _____

8. MARRT DEMOGRAPHICS:

All applicants are requested to provide the following demographics to assist the Association in developing statistical information on it's membership. All information will be kept private and you will not be identified by name. Information will be disclosed to government offices for workload planning and for other uses as determined by the Board.

Gender:	
Male _____	Female _____

Age:		
Less than 25 years _____	35 – 39 _____	50 – 54 _____
25 – 29 _____	40 – 44 _____	55 – 59 _____
30 – 34 _____	45 – 49 _____	60 or over _____

Employment Status:	
Full time _____	Casual _____
Part time _____	Student _____

Employment Information:
Address of place of employment:
City/town:
Phone number:

Workplace Information:	
Hospital _____	Tertiary (Teaching or Referral) _____
	Community urban _____
	Community rural _____
Medical supply/service company _____	
Private clinic _____	
Other (please specify) _____	

Major Areas of Practice (indicate UP to three):		
Acute Care _____	Chronic Care _____	Mixed Acute & Chronic _____
Adult Care _____	Pediatric Care _____	Mixed Adult & Pediatric _____
Home care _____	Sales _____	Teaching _____
Anesthesia _____	Research _____	Equipment Servicing _____
Administration _____	Pulmonary Function Testing _____	
Other, please specify _____		