College of Audiologists & Speech-Language Pathologists of Ontario
3080 Yonge Street, Suite 5060, Box 71, Toronto, Ontario M4N 3N1 ● Tel: 416-975-5347 1-800-993-9459 ● Fax: 416-975-8394

CHANGE OF REGISTER INFORMATION

Pursuant to the *Health Professions Procedural Code*, the member's name, class of registration, business address and business telephone number is information that is available to the public. If a member provides their home address as their business address, their home address will be information, which is available to the public and may be listed as "Private Practice".

Please make any necessary address changes on this form and mail to the address above or to the fax number above. Please complete both sides of the form. This form **MUST be signed and dated in order to be valid**.

To Change your Name in the Public Register

Registration Number: _____ Preferred E- mail_____

Registered Name (First) _____

Middle Name(s) _____

Last Name _____

REGISTERED NAME

The member's registered name must be the name that the member uses in their practice. If changes need to be made, please provide the College with **proof of name change** (marriage/divorce certificate or evidence of legal name change).

New Registered Name _____

Signature _____Date_____

NAME:	
To Update your Residential Address and Telephone Number	
Street:	Apt. No:
City:	Province:
Postal Code:	Telephone No.
Effective Date:	

Please check which will be your Preferred Mailing Address:

☐Residential ☐Business Other (Please specify) _____

Signature _____Date_____

CURRENT PRIMARY BUSINESS INFORMATION *If you are renewing your certificate as a Life(Retired) or Non-Practising member, or changing the class of your certificate to Life (Retired) or Non-Practising, skip this section*

Organization:

Department:

CASLPO By-law 7A provides that Members shall have professional liability insurance in the amount of at least $2,000,000 per claim.

NOTE: 1. If you do not have professional liability insurance, you are not eligible to renew your General or Initial Certificate of Registration until this requirement has been met.
2. CASLPO may require you to provide proof of your professional liability insurance coverage.

☐ I hold or am otherwise covered by professional liability insurance for a minimum of $2,000,000.00 per claim that covers me when I work at the above-mentioned business. (*Academic members may skip this question if within the scope of his or her practice, the member is not directly responsible for providing or deciding to provide any clinical services.*)

What is your **primary practice setting** at this practice site? Check only one. (*Refer to guide for full definitions)*

☐ Hospital ☐ Group Health Centre ☐ Board of Health or Public Health Unit
☐ Rehabilitation Facility ☐ Residential/Long-Term Care Facility ☐ Nurse Practitioner Led Clinic
☐ Mental Health and Addiction Facility ☐ Other Group Practice Office ☐ Solo Practice Office
☐ Client's Environment ☐ Post-Secondary Educational Institution ☐ Preschool/School System/Board of Education
☐ Community Health Centre (CHC) ☐ Family Health Team (FHT) ☐ Children Treatment Centre (CTC)
☐ Community Care Access Centre (CCAC) ☐ Health Related Business/Industry ☐ Cancer Centre
☐ Assisted Living Residence/Supportive Housing ☐ Association/Government/Regulatory Organization/Non-Government Organization)
☐ TeleHealth Ontario or other Telephone Health Advisory Services ☐ Other Place of Work

What are the **major services** that you provide at this practice site? Check only one. *(Refer to guide for definitions)*

☐ General Service Provision ☐ Critical Care ☐ Acute Care ☐ Continuing Care
☐ Comprehensive Primary Care ☐ Public Health ☐ Mental Health and Addiction ☐ Cancer Care
☐ Geriatric Care ☐ Palliative Care ☐ Sales ☐ Quality Management
☐ Post-Secondary Education ☐ Consultation ☐ Research ☐ Administration
☐ Chronic Disease Prevention and Management ☐ Other Area of Direct Service/Consultation ☐ Other Areas

What is your **employment relationship** at this practice site? Check only one. *(Refer to guide for full definitions)*

☐ Permanent *(indeterminate duration of employment and guaranteed or fixed practice hours per week)*
☐ Temporary *(fixed duration of employment, based on a defined start and end date)*
☐ Casual *(on an as-needed basis)* ☐ Self-employed *(a person who operates his or her own economic enterprise in the profession)*

What is your **employment status** at this practice site? Check only one. (*Refer to guide for full definitions)*

☐ Full-Time *(your usual hours of practise are 30 hours or more per week or this is your official status with your employer)*
☐ Part-Time *(your usual hours of practise are less than 30 hours per week or this is your official status with your employer)*
☐ Casual (*your official status with your employer is on an as-needed basis*)

What is your **primary role** at this practice site? Check only one. *(Refer to guide for definitions)*

☐ Administrator ☐ Manager ☐ Salesperson ☐ Consultant ☐ Owner/Operator
☐ Service Provider ☐ Instructor/Educator ☐ Quality Management Specialist ☐ Researcher

What age ranges do you work with at this practice site? Check all that apply.

☐ Preschool (0-5 years) ☐ School Age (6-17 years) ☐ Adults (18 to 64 years)
☐ Seniors (65 years and up) ☐ All Ages ☐ Not Applicable

What age range best describes the main patient/client population that you most often work with at this practice site? Check only one.

☐ Preschool (0-5 years) ☐ School Age (6-17 years) ☐ Adults (18 to 64 years)
☐ Seniors (65 years and up) ☐ All Ages ☐ Not Applicable

Telephone Number: Ext

Toll Free Number: Private Practice: ☐ Yes ☐ No

Street #, Name, Type, and Direction (e.g. 1234 Main Street North)

Unit Type, Unit Number, PO Box Address or Rural Route, Floor, Building (e.g. Apt. 10, PO Box 125, 2nd Floor, Bldg. A) – If applicable

Postal Code:

City: Province/State: Country:

Members are required to provide details about all current practice locations. Please copy this page as needed for each additional practice location.

CURRENT SECONDARY BUSINESS INFORMATION #_____

If you are renewing your certificate as a Life(Retired) or Non-Practising member, or changing the class of your certificate to Life (Retired) or Non-Practising, skip this section

Organization:

Department:

CASLPO By-law 7A provides that Members shall have professional liability insurance in the amount of at least $2,000,000 per claim.

NOTE: 1. If you do not have professional liability insurance, you are not eligible to renew your General or Initial Certificate of Registration until this requirement has been met.
2. CASLPO may require you to provide proof of your professional liability insurance coverage.

☐ I hold or am otherwise covered by professional liability insurance for a minimum of $2,000,000.00 per claim that covers me when I work at the above-mentioned business. (*Academic members may skip this question if within the scope of his or her practice, the member is not directly responsible for providing or deciding to provide any clinical services.*)

What is your **primary practice setting** at this practice site? Check only one. (*Refer to guide for full definitions)*

☐ Hospital ☐ Group Health Centre ☐ Board of Health or Public Health Unit
☐ Rehabilitation Facility ☐ Residential/Long-Term Care Facility ☐ Nurse Practitioner Led Clinic
☐ Mental Health and Addiction Facility ☐ Other Group Practice Office ☐ Solo Practice Office
☐ Client's Environment ☐ Post-Secondary Educational Institution ☐ Preschool/School System/Board of Education
☐ Community Health Centre (CHC) ☐ Family Health Team (FHT) ☐ Children Treatment Centre (CTC)
☐ Community Care Access Centre (CCAC) ☐ Health Related Business/Industry ☐ Cancer Centre
☐ Assisted Living Residence/Supportive Housing ☐ Association/Government/Regulatory Organization/Non-Government Organization)
☐ TeleHealth Ontario or other Telephone Health Advisory Services ☐ Other Place of Work

What are the **major services** that you provide at this practice site? Check only one. *(Refer to guide for definitions)*

☐ General Service Provision ☐ Critical Care ☐ Acute Care ☐ Continuing Care
☐ Comprehensive Primary Care ☐ Public Health ☐ Mental Health and Addiction ☐ Cancer Care
☐ Geriatric Care ☐ Palliative Care ☐ Sales ☐ Quality Management
☐ Post-Secondary Education ☐ Consultation ☐ Research ☐ Administration
☐ Chronic Disease Prevention and Management ☐ Other Area of Direct Service/Consultation ☐ Other Areas

What is your **employment relationship** at this practice site? Check only one. *(Refer to guide for full definitions)*

☐ Permanent *(indeterminate duration of employment and guaranteed or fixed practice hours per week)*
☐ Temporary *(fixed duration of employment, based on a defined start and end date)*
☐ Casual *(on an as-needed basis)* ☐ Self-employed *(a person who operates his or her own economic enterprise in the profession)*

What is your **employment status** at this practice site? Check only one. (*Refer to guide for full definitions)*

☐ Full-Time *(your usual hours of practise are 30 hours or more per week or this is your official status with your employer)*
☐ Part-Time *(your usual hours of practise are less than 30 hours per week or this is your official status with your employer)*
☐ Casual (*your official status with your employer is on an as-needed basis*)

What is your primary role at this practice site? Check only one. *(Refer to guide for definitions)*

☐ Administrator ☐ Manager ☐ Salesperson ☐ Consultant ☐ Owner/Operator
☐ Service Provider ☐ Instructor/Educator ☐ Quality Management Specialist ☐ Researcher

What age ranges do you work with at this practice site? Check all that apply.

☐ Preschool (0-5 years) ☐ School Age (6-17 years) ☐ Adults (18 to 64 years)
☐ Seniors (65 years and up) ☐ All Ages ☐ Not Applicable

What age range best describes the main patient/client population that you most often work with at this practice site? Check only one.

☐ Preschool (0-5 years) ☐ School Age (6-17 years) ☐ Adults (18 to 64 years)
☐ Seniors (65 years and up) ☐ All Ages ☐ Not Applicable

Telephone Number: Ext

Toll Free Number: Private Practice: ☐ Yes ☐ No

Street #, Name, Type, and Direction (e.g. 1234 Main Street North)

Unit Type, Unit Number, PO Box Address or Rural Route, Floor, Building (e.g. Apt. 10, PO Box 125, 2nd Floor, Bldg. A) – If applicable

Postal Code:

City: Province/State: Country: