The College of Naturopaths of Ontario

To be completed by the patient

Applicant Attestation

The Patient Relations Committee follows the provisions of the Regulated Health Professions Act, 1991 (RHPA) which direct the College in administering the funding program. This form is to be completed once funding has been granted and a therapist/counsellor has been selected by the Applicant.

A. Applicant Information – To Be Filled Out By the Applicant		
Name:		
Address:		
City:	Province:	Postal Code:
Telephone:	Email:	

B. Attestation

I, _____ *[name]* of _____ [*municipality*]

certify that,

1. I do not have a family relationship to _____ [*therapist/counsellor]* of _____ [*municipality]* or any other potential conflict of interest.
2. I understand that if I choose a therapist/counselor who is not a member of a regulated health profession, the therapist/counsellor is not subject to professional discipline by the College of Naturopaths of Ontario or any other regulatory body.
3. I understand that funding will be paid only to the therapist/counsellor, and that it will be used only to pay for therapy or counselling for the sexual abuse that made me eligible for the funding and shall not be applied directly or indirectly for any other purpose.
4. I understand that the maximum amount of funding payable to any therapist/counselor approved under this or any other application to the College 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.
5. I will use the other sources of funding for therapy or counseling that are available to me first (e.g. OHIP, private insurance). This includes:

   _____

   _____

   [Name of provider and amount available]
6. If at any time other sources of funding become available to me, I shall notify the College.
7. I understand that there can be no duplicate payment for the same service.
8. I understand that the College of Naturopaths of Ontario will not pay for any late or missed appointments.

Signature:	Date: