CDHO
COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

Form A – Application for Funding for Therapy or Counselling

APPLICANT'S INFORMATION

SURNAME:	GIVEN NAMES:	MS. ◯ MR. ◯ OTHER:
MAILING ADDRESS:		
CITY:	PROVINCE:	POSTAL CODE:
PRIMARY TELEPHONE NUMBER:	HOME/BUSINESS/CELL:	
EMAIL ADDRESS:		

I currently have a therapist or counsellor (If "YES", please also submit **Form B**)	YES ◯ NO ◯
I am requesting funding for therapy/counselling that I received in the past (If "YES", please also submit **Form C**)	YES ◯ NO ◯
I have coverage through a government or private insurance plan for therapy/counselling.	YES ◯ NO ◯

BY SIGNING BELOW, I ACKNOWLEDGE AND CONFIRM THE FOLLOWING:

1. I am applying for funding for therapy or counselling under the program established by the College of Dental Hygienists of Ontario (the "College") for victims of sexual abuse by a Registered Dental Hygienist.
2. My application will be reviewed and my eligibility for funding will be determined by the Patient Relations Committee of the College. The Patient Relations Committee follows the rules and regulations set out in applicable legislation.
3. I understand that any funding provided by the College will be paid directly to the therapist/counsellor and can only be used for therapy/counselling or other purposes approved by the College.

4. I understand that the amount of funding for therapy/counselling is subject to a maximum limit set out in legislation.
5. I understand that funding for therapy/counselling can be provided for a maximum of five years from the date I become eligible. If I am requesting funding for past therapy/counselling, I can request funding for a maximum of five years from when I first received therapy/counselling.
6. I understand that if my therapist/counsellor is not a regulated professional, they are not subject to professional oversight or discipline by a professional regulatory body, and the College cannot verify whether they have ever been found guilty of sexual abuse or been the subject of a discipline proceeding.
7. I will inform the College of any change to my therapist/counsellor and of any change to my insurance coverage for therapy/counselling.

Applicant Signature

Date

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