

Application for a Certificate of Authorization for a Health Profession Corporation



COLLEGE OF NURSES
OF ONTARIO
ORDRE DES INFIRMIÈRES
ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

Instructions and Checklist

Application forms for a Certificate of Authorization for a Health Profession Corporation ("Corporation") that are incomplete will be returned.

The \$565.00 (includes HST) fee accompanying the application form is non-refundable. The fee must be paid by cheque, money order, debit card or a credit card accepted by the College.

INSTRUCTIONS

Prior to submitting your application form, please ensure that the following criteria have been met:

1. A Director (*must be a member of the College*) authorized to sign on behalf of the Corporation has signed the application form (Part A).
2. The same Director that signed the application form has also signed the required Declaration (Part B).
3. Each Director (*must be members of the College*) of the Corporation has executed an Undertaking in Part C. Please make as many copies of the form as required.
4. Each Shareholder (*must be members of the College*) of the Corporation has executed an Undertaking in Part D in respect of the Corporation. Please make as many copies of the form as required.
5. In completing the application form, if more space is required, attach additional pages labelled appropriately.

CHECKLIST

An application for a Certificate of Authorization for a Health Profession Corporation is considered incomplete without the following enclosures:

1. Signed application form completed by the same Director of the Corporation who signed the Declaration. (See item 3.)
2. Fee in the amount of \$565.00 (includes HST) payable to the College of Nurses of Ontario.
3. Declaration by a Director of the Corporation signed not more than 15 days before the application is submitted to the Executive Director.
4. Certified copy of a corporation profile report issued by the Ministry of Government and Consumer Services (or a service provider under contract to the Ministry) not more than 30 days before the application is submitted to the Executive Director, which indicates that the Corporation is active.
5. Certified copy of the Certificate of Incorporation of the Corporation (*must be issued by the Ministry of Government Services*).
6. Certified copy of every Certificate of the Corporation (*must be issued by the Ministry of Government Services*) that has been endorsed under the *Business Corporations Act (Ontario)* since the Corporation's most recent application for a Certificate of Authorization or for renewal of its Certification of Authorization.
7. Undertaking in Part C to be completed by each Director of the Corporation.
8. Undertaking in Part D to be completed by each Shareholder of the Corporation (excluding Director(s) who have completed Part C).



Application for a **Certificate of Authorization** for a Health Profession Corporation

ONTARIO CORPORATION NO. ISSUED BY MINISTRY

1) NAME OF HEALTH PROFESSION CORPORATION

Note: The name of the Corporation must comply with the requirements of s.1 of Ontario Regulation 39/02 of the *Regulated Health Professions Act, 1991*.

2) BUSINESS ADDRESS OF HEALTH PROFESSION CORPORATION

STREET		SUITE
CITY	PROVINCE	POSTAL CODE
TEL	FAX	E-MAIL (optional)

3) NAME(S) OF SHAREHOLDER(S) AS OF THE DAY THE APPLICATION IS SUBMITTED (must be a member of the College) AND HIS/HER BUSINESS ADDRESS, BUSINESS TELEPHONE NUMBER AND REGISTRATION NUMBER WITH THE COLLEGE AS OF THAT DAY.

		College Registration #
Last Name	Given Names (underline one commonly used)	
Business Address (Street)	Suite	
City	Province	Postal Code
Telephone	Fax	E-Mail
Director <input type="checkbox"/>	Officer <input type="checkbox"/>	Provide Title of Office

		College Registration #
Last Name	Given Names (underline one commonly used)	
Business Address (Street)	Suite	
City	Province	Postal Code
Telephone	Fax	E-Mail
Director <input type="checkbox"/>	Officer <input type="checkbox"/>	Provide Title of Office

		College Registration #
Last Name	Given Names (underline one commonly used)	
Business Address (Street)	Suite	
City	Province	Postal Code
Telephone	Fax	E-Mail
Director <input type="checkbox"/>	Officer <input type="checkbox"/>	Provide Title of Office

(Attach additional pages appropriately labelled, if necessary.)

College Registration # _____

Last Name _____ Given Names (underline one commonly used) _____

Business Address (Street) _____ Suite _____

City _____ Province _____ Postal Code _____

Telephone _____ Fax _____ E-Mail _____

Director Officer Provide Title of Office _____

4) NAME(S) OF INDIVIDUAL(S) (must be a member of the College) WHO WILL PRACTISE ON BEHALF OF THE CORPORATION, INCLUDING ALL SHAREHOLDERS AND NURSING EMPLOYEES OF THE CORPORATION, AS OF THE DAY APPLICATION WAS SUBMITTED.

COLLEGE REGISTRATION #	FULL NAME

5) THE CORPORATION INTENDS TO PRACTISE AND/OR CARRY ON BUSINESS IN THE FOLLOWING LOCATION(S):

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

Street _____ Suite _____

City _____ Postal Code _____ Business Phone _____

6) PLEASE PROVIDE A BRIEF DESCRIPTION OF THE PROFESSIONAL ACTIVITIES CARRIED OUT BY THE CORPORATION.

Note: The Corporation cannot carry on, and cannot plan to carry on, any business that is not the practice of nursing, or activities related or ancillary to the practice of nursing (Regulation 39/02, subparagraph 6(ii) of subsection 2(1)).

I confirm that the information contained in this Application for a Certificate of Authorization for a Health Professional Corporation is complete and accurate.

Signature of Officer/Director authorized to sign on behalf of the Corporation _____ Date _____

Please print name _____ College Registration Number _____

Please fill out this payment slip.

Payment can be made by credit card, money order or cheque (if payment is made by cheque, please allow an extra five (5) days for processing). **Please DO NOT DETACH**

Cheque or Money Order (in Canadian funds ONLY — made payable to College of Nurses of Ontario)

Form for payment by VISA, MasterCard or American Express Office use: Authorisation # _____

Please print all information clearly.

Corporation Name _____ Name on Credit Card _____ COA Number _____

VISA MasterCard American Express Amount: \$565.00 includes HST

_____-_____-_____-_____-_____-_____-_____-_____- Expiry Date /
(Credit card payments are billed in Canadian funds) M M Y Y

HST #: R106953904

Signature of Card Holder _____

PART B

TO BE EXECUTED BY A *DIRECTOR* ONLY

Declaration

I, _____, a director of _____,
[Insert Full Name of Nurse] [Insert Full Name of Health Profession Corporation ("Corporation")]

do hereby certify that the following statements are true:

1. I am a member of the College of Nurses of Ontario holding Certificate of Registration No. _____.
2. I am a director of the Corporation and have the authority to apply for a Certificate of Authorization.
3. The Corporation is in compliance with section 3.2 of the *Business Corporations Act (Ontario)* as of the date this Declaration is signed.
4. The Corporation does not plan to carry on, and will not carry on, any business that is not the practice of nursing or an activity related or ancillary to the practice of that profession.
5. There has been no change in the status of the Corporation since the date of the certificate of status enclosed with the Application for a Certificate of Authorization that accompanies this Declaration.
6. The information contained in the Application for a Certificate of Authorization that accompanies this Declaration is complete and accurate as of the day this Declaration is signed.

(Signature of Declarant)

(Date)

TO BE EXECUTED BY EACH DIRECTOR

Undertaking

Each Director of the Health Profession Corporation is required to execute a separate Undertaking.

I, _____, a member of College of Nurses of Ontario
Name of Director

(“College”) and a shareholder of _____ UNDERTAKE TO
Name of Corporation (“Corporation”) THE COLLEGE AS FOLLOWS:

1. I accept professional responsibility for any act or omission of the Corporation that would be professional misconduct if such an act or omission had been committed or omitted by a member of the College.
2. I will ensure that the Corporation does not do or cause to be done, or omit or cause to be omitted, anything that would be professional misconduct if done or omitted to be done by a member of the College.
3. I will ensure that the Corporation does not engage in the practice of nursing, or any activity related or ancillary to the practice of that profession, unless it maintains a valid Certificate of Authorization issued by the College.
4. I will ensure that the Corporation does not practise under any name other than the name of the Corporation, a practice name previously approved by the College for use by a shareholder of the Corporation or a name permitted by Regulation.
5. I will ensure that the Corporation complies with the *Regulated Health Professions Act, 1991*, the *Nursing Act, 1991*, the regulations made under those Acts, and the bylaws of the College.
6. I will ensure that the College is notified immediately of any change in shareholders of the Corporation and that any future shareholder of the Corporation execute and file with the College, within ten (10) days of becoming a shareholder of the Corporation, an Undertaking in a form approved by the College.
7. I will ensure that the College is notified of any changes to practice locations of the Corporation as soon as they occur.
8. I will ensure that the College is notified within ten (10) days if I cease to be a director of the Corporation.
9. I acknowledge that a breach of this Undertaking may result in referral of specified allegations of professional misconduct against me to the Discipline Committee arising out of my failure to abide by any of the terms of this Undertaking.
10. I acknowledge having been advised to obtain independent legal advice prior to signing this Undertaking.

Signature of Director

Signature of Witness

Name of Director (please print)

Name of Witness (please print)

Date

PART D

TO BE EXECUTED BY EACH **SHAREHOLDER**

Undertaking

Each Shareholder of the Health Profession Corporation is required to execute this Undertaking.

I, _____, a member of College of Nurses of Ontario
Name of Shareholder

(“College”) and a shareholder of _____ UNDERTAKE TO
Name of Corporation (“Corporation”) THE COLLEGE AS FOLLOWS:

1. I accept professional responsibility for any act or omission of the Corporation that would be professional misconduct if such an act or omission had been committed or omitted by a member of the College.
2. I will ensure that the Professional Corporation does not do or omit to do anything that would be professional misconduct if done or omitted to be done by me.
3. I will ensure that the College is notified within ten (10) days if I cease to be a shareholder of the Corporation.
4. I acknowledge that a breach of this Undertaking may result in referral of specified allegations of professional misconduct against me to the Discipline Committee arising out of my failure to abide by any of the terms of this Undertaking.
5. I acknowledge having been advised to obtain independent legal advice prior to signing this Undertaking.

Signature of Shareholder

Signature of Witness

Name of Shareholder (please print)

Name of Witness (please print)

Date