



PROVISIONAL PRACTICE *with Restrictions*

PLAN AND AGREEMENT

This document must be submitted to the College before a Certificate of Provisional Practice with Restrictions can be granted.

Name of Physiotherapy Resident: _____

Primary supervising physiotherapist

The Primary Supervisor is the physiotherapist who will provide the majority of supervision and complete all reports for the College. When there is more than one supervisor involved, the Primary Supervisor will ensure coordination and ongoing communication between all parties. The Primary Supervisor will be the main contact with the Resident, the College and any other supervisors.

The Primary Supervisor of this resident is:

Name: _____

Facility Name: _____

Business Address of Supervisor: _____

Business Telephone: _____

Is this the site where the supervision will occur? Yes No

If no, please provide the facility name, business address and telephone number of the site where the supervision will occur.

Facility Name: _____

Facility Address: _____

Facility Telephone Number: _____

1.0 Supervisors*

* Supervisors must have a minimum of two years of physiotherapy practice experience.

** Typically there will be one Primary Supervisor who may be assisted by a second supervising therapist. A third supervisor may be identified to support the supervision of a resident in the event of illness or vacation.

	Supervisor Name	Registration Number	Estimated hours of supervision
Primary	_____	_____	_____
Secondary	_____	_____	_____
Third**	_____	_____	_____



2.0 Overall Coordination

If more than one Supervisor will be involved, describe how the Primary Supervisor will organize the overall coordination of the supervision. Describe how the Primary Supervisor will ensure effective feedback and communication is maintained between all parties.

3.0 Supervision Plan

Describe how you will supervise this resident. Supervision must include the following activities; formal and informal observation, review of documentation, case reviews, meetings with the Resident and input from team members. Supervision may also include chart audit, demonstration of skills, formal performance review or project management. Supervision requires that you (or another Supervisor) be onsite at all times when the Resident is involved in direct patient care.

4.0 Resident's Caseload

Please describe the Resident's caseload (e.g. orthopaedic, neurological) and the typical number of patients per day.



PLEASE RETURN BY FAX
OR MAIL TO:

**COLLEGE OF
PHYSIOTHERAPISTS**

375 University Avenue
Suite 901
Toronto, Ontario
M5G 2J5

ATTENTION: ENTRY TO
PRACTICE ASSOCIATE

Telephone:

416-591-3828 OR
1-800-583-5885

Fax: 416-591-3834



Applicant

I _____ agree to comply with the terms, conditions and limitations associated with a Certificate Authorizing Provisional Practice with Restrictions. I agree that I shall only practice as a registrant of the College of Physiotherapists holding a Provisional Practice with Restrictions Certificate while under the supervision of the person named in this agreement and at the specified facility. I agree to assume responsibility for informing the College of any proposed changes to the Provisional Practice with Restrictions Plan and understand that in the event that either the supervisor or employment facility changes, I will be required to submit a new application, which must be approved by the College before I can resume Provisional Practice with Restrictions. I understand that I will continue to use the term Physiotherapy Resident and that this Certificate for Provisional Practice with Restrictions will not be re-issued.

Signature of Applicant

Date mm / dd / yyyy

Supervisor

I agree to provide supervision for the above named applicant in accordance with the **Requirements and Responsibilities** specified by the College regarding Provisional Practice with Restrictions. I agree to comply with this Provisional Practice with Restrictions Plan and understand that I am agreeing to directly supervise this Physiotherapy Resident. As part of my supervisory responsibilities, I agree to formally evaluate the resident and will report (within one business day) to the College of Physiotherapists of Ontario any professional practices, incidents, conduct, incompetence or incapacity on the part of the applicant that in any way may adversely affect patient care or public safety. I will notify the College immediately if I am unable to fulfill my responsibility as a Supervisor.

Signature of Primary Supervisor

Date mm / dd / yyyy

Signature of Supervisor (2)

Date mm / dd / yyyy

Signature of Supervisor (3)

Date mm / dd / yyyy

Signature of Clinic Owner, Manager, or Employer

Date mm / dd / yyyy



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