MCKENZIE INSTITUTE CANADA

ACCREDITED CLINICIAN APPLICATION

First Name: Last Name:

Clinical Practice Location 1:

Clinic Name:

Clinic Address:

City, Province, Postal Code:

Do you own the clinic listed above?: ☐YES ☐NO

Please check the most appropriate: ☐ Hospital ☐ Private Clinic ☐Other

Typical age of patients: ☐All ages ☐Mostly Adult ☐Mostly Seniors 65+ ☐Mostly Youths 13-18

Are you currently accepting new patients? ☐YES ☐NO

Does your work site accept WSIB patients? ☐YES ☐NO

Main areas of practice:

Clinical Practice Location 2 *(If applicable):*

Clinic Name:

Clinic Address:

City, Province, Postal Code:

Do you own the clinic listed above: ☐YES ☐NO

Please check the most appropriate: ☐ Hospital ☐ Private Clinic ☐Other (free flow box)

Typical age of patients: ☐All ages ☐Mostly Adult ☐Mostly Seniors 65+ ☐Mostly Youths 13-18

Are you currently accepting new patients? ☐YES ☐NO

Does your work site accept WSIB patients? ☐YES ☐NO

Main areas of practice:

Professional & Practice Information:

*Please answer **ALL** of the following questions below:*

Profession:

Licencing Province: Licence Number:

Liability Insurance Provider: Validity/Expiration Date:

If applicable, year you attained Diploma in MDT:

Year you Credentialed in MDT:

I am currently CCES compliant and listed on the McKenzie Provider Locator ☐YES ☐NO

Have you ever had a finding of professional misconduct, incompetence or incapacity against you?☐YES ☐NO

If yes, please provide details

Have you ever had your professional licence suspended or taken away (revoked)?☐YES ☐NO

If yes, please provide details

Have you ever been found guilty of an offense, professional negligence or malpractice? ☐YES ☐NO

If yes, please provide details

Do you currently?

☐YES ☐NO Use MDT to assess and classify all your MSK patients?

☐YES ☐NO Use McKenzie Assessment Forms when assessing your patients?
If no, why not:

☐YES ☐NO Collect data to measure your outcomes?
If yes, what instruments / system are you currently using to collect data?

☐YES ☐NO Use any modalities on a regular basis?
If yes, please list them and state the reasons for use?

☐YES ☐NO Try to discharge patients as expediently as possible as their problem resolves?

Cert. MDT only: In your own words, state why do you think its important to become an MIC Accredited Clinician?

Submitted with application:

- ☐ Updated CV
- ☐ Copy of professional license
- ☐ Copy of current professional liability insurance
- ☐ Payment of 2017 fees Processed Online

The Accredited designation will not be activated until 15APR therefore the annual fees have been reduced accordingly. Your 2017 Annual Membership will be valid until 31DEC, 2017. Upon renewal of your Accredited designation at the end of 2017, your membership will be re-instated until 31DEC, 2018. Please refer to the Accredited Clinician Criteria document for information on the annual fees starting in 2018.

☐ $175.00 Cert. MDT Fee, including MICanada Annual Membership (valid until 31DEC, 2017)

☐ $75.00 Dip. MDT Fee including MICanada Annual Membership (valid until 31DEC, 2017)

☐ $0.00 Fee, only for 2017, Dip MDT working at Certified McKenzie Clinic (JMMT & Patient Brochures restrictions apply)

Confirmation of Fee Payment:

First & Last 4 digits of the credit card used to pay the application fees online:_____

Signature of Cardholder agreeing to the fees stated above: _____

Terms & Conditions:

By submission of this application and payment of the fee, I agree to the following:

1. I agree to meet the conditions outlined in the Accredited Clinician Criteria and if my application is accepted by the Robin McKenzie Institute Canada (MICanada), my signature below signifies my agreement to the terms and conditions outlined in the Accredited Clinician Criteria.
2. I accept the fact that the Accredited Clinician status is only recognized in Canada and that anywhere other than Canada, I will be recognized as Dip MDT, Cred. MDT or Cert. MDT.
3. I agree that the Robin McKenzie Institute Canada branch can immediately recall my Accredited status for the following reasons:
   A. Professional licence recalled or under investigation by professional licencing body
   B. Failure to hold and provide proof of professional liability insurance
4. I agree to provide my patients with information regarding the online patient survey
5. I understand that the Accredited designation is re-evaluated every year and that renewals are subject to my ongoing ability to follow the specified criteria.
6. I grant MICanada permission to publish my name, clinical practice information, in all relevant marketing material

Signature: _____ Date: _____

OFFICE USE:

Application submission date: (text box)

- ☐ CV
- ☐ Copy of professional license
- ☐ License verified with provincial college
- ☐ Copy of current professional liability insurance
- ☐ Payment of fee: Amount Paid: _____ Date Received:

☐ Database Member Information Updated

CCES Compliance Date

Application Approval Date:

Case Manager Pass Mark

☐ Membership Activation Until 31DEC, 2017

☐ Admin Tool Activation

Admin Activation Date

☐ Database Student/Member Status Updated

☐ Provider Locator Verification

☐ Distribution of MDT Patient Brochures & Window Decals

Patient Survey I.D.

Patient Survey Follow-up 1

Patient Survey Follow-up 2

Patient Survey Follow-up 2

General Comments:

If applicable: 2018 Renewal Date

☐ Deactivated / No Renewal