Ontario

Ministry of Health

Application for Authorizer Status

Assistive Devices Program (ADP)
5700 Yonge Street, 7th Floor
Toronto ON M2M 4K5

Section 1 – Mailing Address

Last Name	First Name	Middle Initial

Address

Unit Number	Street Number	Street Name

Lot/Concession/Rural Route	City/Town	Province	Postal Code

Business Telephone Number	Fax Telephone Number	Email Address

Section 2 – Details

Device category for which you are applying.

Refer to Attachment A on the ADP Web site for professions eligible for authorizer status for each category. A separate application is required for each category; device sub-categories can be combined in one application.

- ☐ Bone Anchored Hearing Aid Replacement Sound Processor
- ☐ Cochlear Implant Replacement Speech Processor
- ☐ Communication Aids
- ☐ Conventional Limb Prostheses
- ☐ Externally Powered Upper Limb Prostheses
- ☐ Maxillofacial Extraoral Prostheses
- ☐ Maxillofacial Intraoral Prostheses
- ☐ Ocular Prostheses
- ☐ Orthotics
- ☐ Visual Aids (High-Tech)
- ☐ Visual Aids (Low-Tech)

Hearing Aids – sub-categories:

- ☐ Adult
- ☐ Children

Mobility Devices – sub-categories:

- ☐ Ambulation Aids
- ☐ Power Scooters
- ☐ Wheelchairs (Manual) and Positioning Aids
- ☐ Wheelchairs (Power) and Positioning Aids

Pressure Modification Devices – sub-categories:

- ☐ Hypertrophic Scar Management
- ☐ Lymphedema Management

If you are currently a registered authorizer with the ADP, specify your authorizer number

Indicate your profession

- ☐ Anaplastologist
- ☐ Audiologist *
- ☐ Certified Ocularist
- ☐ Certified Orthotist
- ☐ Certified Prosthetist
- ☐ General Dentist *
- ☐ Hearing Instrument Specialist
- ☐ High-Technology Visual Aids Authorizer
- ☐ Occupational Therapist *
- ☐ Ophthalmologist *
- ☐ Optometrist *
- ☐ Orientation and Mobility Instructor
- ☐ Physiotherapist *
- ☐ Prosthodontist *
- ☐ Regional Assessment Centre / CCTV Authorizer
- ☐ Registered Nurse *
- ☐ Registered Massage Therapist *
- ☐ Restorative Prosthetist
- ☐ Specialist Teacher of the Blind
- ☐ Speech-Language Pathologist *
- ☐ Vision Rehabilitation Teacher
- ☐ Vision Rehabilitation Worker

*** Provide Regulatory College number (if applicable) and Year obtained**

Regulatory College number (if applicable)	Year obtained

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Section 3 – Experience

Specify and briefly describe other relevant formal or informal educational programs, workshops, manufacturer's training programs, conferences completed/attended in the past 5 years.

Describe your experience in prescribing/assessing/fitting the device for which you are seeking ADP authorizer status.

Section 4 – Employment Locations

If in private practice, this section must also include all companies who are currently employing the applicant's service.

Location 1

Employer's Name

Is this your preferred mailing address?

☐ Yes ☐ No (Default to Mailing Address in Section 1)

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route		City/Town	Province	Postal Code
Business Telephone Number	Fax Telephone Number	Email Address		

Location 2

Employer's Name

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route		City/Town	Province	Postal Code
Business Telephone Number	Fax Telephone Number	Email Address		

Location 3

Employer's Name

Address

Unit Number	Street Number	Street Name		
Lot/Concession/Rural Route		City/Town	Province	Postal Code
Business Telephone Number	Fax Telephone Number	Email Address		

Use Attachment B for additional locations

Section 5 – Confirmation

The information provided on this form is true, correct and complete to the best of my knowledge. I understand that I will have to sign and comply with the terms specified in the Authorizer Agreement and the Conflict of Interest Protocol.

Signature	Date (yyyy/mm/dd)