College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Agenda

Meeting of Council

Friday, December 7, 2018
0900 hours — 1600 hours
CMRTO Council Room

NOTE: In reviewing the material for this meeting, if you become aware that you have a conflict of interest with any item on the agenda or are concerned that you may have a conflict of interest with any item on the agenda, you are asked to please contact Linda Gough or the Chair of the Committee immediately.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Agenda

Meeting of Council

Friday, December 7, 2018
0900 hours — 1600 hours
CMRTO Council Room

Item	By	Page#	Time
1. Call to Order	W. Rabbie		0900 hrs
a. Approval of the agenda			
b. Review of Roles & Responsibilities of Council			
i. CMRTO Policy 2.11, Roles & Responsibilities of the Council, effective date June 19, 2014, last reviewed September 2017		1 – 5	
ii. CMRTO Policy 2.12, Code of Conduct for Council and Committee Members, effective date September 23, 2014, last reviewed September 2017		6 – 9	
c. Council Composition			
i. Report to Council from the Registrar & CEO, dated November 25, 2018, regarding 'Council Composition'		10 – 11	
2. Declaration of Conflict of Interest			
3. Minutes of the previous meeting	W. Rabbie		
a. September 27, 2018			
i. Minutes of meeting of Council held on September 27, 2018		12 – 25	

Item		By	Page#	Time
ii.	In Camera Minutes of the meeting of Council of September 18, 2018 – Agenda item 4d: External Financial Auditors (to be circulated at the meeting)			
iii.	In Camera Minutes of the meeting of Council of September 18, 2018 – Agenda item 6e: Office Lease (to be circulated at the meeting)			
iv.	Report to Council from the Executive Committee, dated November 19, 2018, regarding 'Office Lease'		26	
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ii.	CMRTO Policy 2.8, Terms of Reference for the Finance and Audit Committee, effective date June 19, 2014, last amended September 26, 2017		28 – 30	
b.	**Financial Report for Q3 2018**	J. Neadles		
i.	Report to Council from the Finance and Audit Committee, dated November 7, 2018 regarding 'Financial Report to Council for Q3 2018 (July 1 – September 30, 2018)', with the following attachments:		31 – 32	
	• CMRTO Summary of Statement of Revenue & Expenses for the period ending September 30, 2018		33	
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Item	By	Page#	Time
• Cost of Sonography Regulation for the period ending September 30, 2018		36	
c. Investment Report for Q3 2018	J. Neadles		
i. Report to Council from the Finance and Audit Committee, dated November 7, 2018 regarding 'Investment Report to Council for Q3 2018 (July 1 – September 30, 2018)', with the following attachment:		37	
• CIBC Wood Gundy, Portfolio Evaluation as of September 30, 2018		38	
5. Strategic Plan & Reports	W. Rabbie		
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b. Balanced Scorecard Report	L. Gough		
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• Insights – Fall 2018		63 – 70	
iii. Email to CMRTO members, from CMRTO Quality Assurance, dated November 1, 2018, regarding 'CMRTO QA Reminder'		71 – 72	

iv. Email to CMRTO members and applicants, from CMRTO Communications, dated November 14, 2018, regarding 'What you must know about...performing procedures... and mandatory reporting', with the following attachments: 73 – 74

- WYMKA... performing procedures for medical radiation and imaging technologists, dated November 2018 75 – 95
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d. Quality Assurance

i. Report to Council from Sandra Willson, Chair, Quality Assurance, regarding 'Quality Assurance assessments for 2019'
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e. 2018 Year End Update

i. Report to Council from Linda Gough, Registrar & CEO, regarding '2018 Year End Report'
(to be circulated at the meeting)

6. For Decision

a. 2019 Operational Plan L. Gough

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ii. 2019 Operational Plan, Commitment to Regulatory Excellence, Draft 2, dated November 19, 2018 102 – 113

b. CMRTO Staff Salary Ranges W. Rabbie

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ii.	Report to Council from the Executive Committee, dated November 19, 2018 regarding 'CMRTO Salary Ranges'		115 – 116
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ii.	Draft CMRTO 2019 Budget, dated December 7, 2018		119 – 120
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d.	**Diagnostic Medical Sonographers**	W. Rabbie	
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iii.	Email to sonography applicants and CMRTO members, from Linda Gough, Registrar & CEO, dated October 18, 2018, regarding 'Urgent update for all sonographers: You cannot work effective January 1, 2019 if you are not REGISTERED with CMRTO'		126 – 127
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g.	**Policy Review: Administration**		
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ii.	Administration Policy 1.2 – Social Media Terms of Use, effective date September 23, 2014, last reviewed September 2017, with proposed updates		175 – 179

i. Policy Review: Election and Appointment

j. Policy Review: Finance and Risk

I. Policy Review: Registration

8. Education Session The Perils of Prediction: Legal Issues for Regulation in the Age of Big Data	John Risk, WeirFoulds LLP	1430 – 1530hrs
9. Meeting Evaluation	W. Rabbie	
i. Post meeting Evaluation: Council Meeting December 7, 2018		360 – 361
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College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Roles and Responsibilities of the Council

Policy 2.11

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy

The Council of the College of Medical Radiation Technologists of Ontario (CMRTO) acts as the board of directors of the CMRTO and is responsible for managing and administering its affairs.[1] The Council is responsible for regulating the profession of medical radiation technology in the public interest. It achieves this through policy-making, goal and priority setting, planning, decision-making and oversight.

In carrying out its role, the CMRTO Council shall:

1. Fulfill the legislated responsibilities set out in the *Regulated Health Professions Act, 1991*, including the Health Professions Procedural Code, the *Medical Radiation Technology Act, 1991* and the regulations made under those Acts, to ensure that all the statutory responsibilities of the CMRTO, its statutory committees and its employees are met[2]

2. Establish and review the CMRTO's regulations and by-laws

3. Establish and review CMRTO policies, position statements, and guidelines in accordance with relevant legislation

4. Maintain the financial integrity of CMRTO

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[1] Section 4 of the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*.

[2] The statutory duties and objects of the CMRTO set out in legislation are attached to this policy as Appendix 1.

5. Consider and recommend any changes to legislation necessary for the CMRTO to meet its mandate

6. Establish and review the standards of practice for the profession and other policies relevant to protecting the public interest

7. Establish and promote the CMRTO's mission, vision and values

8. Develop, approve and regularly revise the strategic plan of the CMRTO consistent with its statutory obligations and the mission, vision and values

9. Oversee the evaluation of the CMRTO's activities and assess the CMRTO's achievement of its strategic plan

10. Allocate resources by setting broad budget priorities based on the strategic plan, approve budgets based on these priorities, and monitor financial performance

11. Monitor and evaluate the governance framework of the CMRTO regarding committees, financial management, risk management and reporting to ensure compliance with requirements and to monitor performance

12. Receive reports from all statutory committees, non-statutory committees and task forces

13. Review and monitor its own effectiveness as a governing body

Composition

The Council is comprised of:

- Eight (8) Councillors who are members of the CMRTO (elected members)
- Between five (5) and seven (7) Councillors appointed by the Lieutenant Governor in Council (public members)

The President and Vice-President are elected annually from the elected members of Council. A majority of the members of Council, at least three of whom are members of the CMRTO and at least one of whom was appointed by the Lieutenant Governor in Council, shall constitute a quorum.

The Registrar & CEO shall attend all meetings of Council except for personnel matters related to the Registrar & CEO and declared by the President to require in camera deliberation.

Appendix 1

Review of duty and objects of the College

Below are some excerpts from the Health Professions Procedural Code, made under the *Regulated Health Professions Act, 1991*, setting out the statutory duty and objects of the College and provisions regarding Council meetings.

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of College

3. (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.

5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991.*
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.

9. To promote inter-professional collaboration with other health profession colleges.

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

Council

4. The College shall have a Council that shall be its board of directors and that shall manage and administer its affairs. 1991, c. 18, Sched. 2, s. 4.

Quorum

6. A majority of the members of the Council constitute a quorum. 1991, c. 18, Sched. 2, s. 6.

Meetings

7. (1) The meetings of the Council shall be open to the public and reasonable notice shall be given to the members of the College, to the Minister, and to the public. 2007, c. 10, Sched. M, s. 20 (1).

Exclusion of public

(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(a) matters involving public security may be disclosed;

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;

(d) personnel matters or property acquisitions will be discussed;

(e) instructions will be given to or opinions received from the solicitors for the College; or

(f) the Council will deliberate whether to exclude the public from a meeting or whether to make an order under subsection (3). 1991, c. 18, Sched. 2, s. 7 (2); 2007, c. 10, Sched. M, s. 20 (2).

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Code of Conduct for Council and Committee members

Policy 2.12

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 23, 2014	**Review Schedule:**	Every 3 years
Effective Date:	September 23, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

In carrying out its objects,[1] the College of Medical Radiation Technologists of Ontario (CMRTO) has a duty to serve and protect the public interest. The CMRTO's Council and its committees are committed to ensuring that, in all aspects of its affairs, the CMRTO maintains public trust by acting honestly and with integrity and in accordance with its mandate.

Application

This policy applies to members of the Council and members of CMRTO's committees. In this policy, members of the Council and members of committees are together referred to as "members" and individually as a "member".

Duties

All members of the Council have a fiduciary responsibility to the CMRTO as a result of being members of the CMRTO's board of directors and are bound by the obligations that arise out of their fiduciary duties. All members of the Council shall act in the best interests of the CMRTO and of the public and shall not act in any way in the interests of any group or segment of the CMRTO or the public if such interests are not in the best interests of the CMRTO or the public as a whole.

All members shall act with honesty and integrity and shall be loyal to the CMRTO. A member shall not put self or personal interests ahead of their statutory responsibilities or the interests of the CMRTO.

[1] The CMRTO's objects are set out in section 3 of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*.

Every member shall act in the best interests of the public receiving services from medical radiation technologists in Ontario. No member by reason of their election or appointment shall conduct themself as a representative of any professional, socioeconomic, cultural, or geographic group or other constituency.

Members shall comply with all laws applicable to the CMRTO, including, without limitation, the *Regulated Health Professions Act, 1991* (the RHPA), the *Medical Radiation Technology Act, 1991*, the regulations made under either of those Acts and the CMRTO's by-laws. Members shall also at all times adhere to and respect the policies of the CMRTO and shall not engage in conduct or actions which are detrimental to the CMRTO or contrary to any of its policies.

Confidentiality

Every member must adhere to the provision regarding confidentiality set out in the RHPA which states that every member of a Council or committee of a College shall keep confidential all information that comes to their knowledge in the course of their duties and shall not communicate any information to any other person, except in certain limited circumstances.[2] Every member is required to sign a confidentiality agreement in the form approved by the CMRTO's Council, from time to time, at the commencement of the member's term of office, and thereafter when there are any changes to the form of confidentiality agreement.

Spokespersons

The President is the official spokesperson for the Council. It is the role of the President to represent the voice of the Council to all stakeholders.

The Registrar & CEO is the official spokesperson for the CMRTO. It is the role of the Registrar & CEO to represent the voice of the CMRTO to all stakeholders.

No member shall speak or make representations on behalf of the Council, the CMRTO or its committees unless authorized by the President (or, in the President's absence, the Vice-President) and the Registrar & CEO or by the Council. When so authorized, the member's representations must be consistent with accepted positions and policies of the CMRTO.

Media Contact and Public Discussion

News media contact and statements and public discussion of the CMRTO's affairs should only be made through one of the official spokespersons or other spokesperson authorized in the manner described above. Any member who is questioned by news reporters or other media representatives should refer such individuals to the Registrar & CEO.

Personal Conduct

All members must conduct themselves in a professional, respectful and courteous manner when conducting CMRTO business. Members must not engage in verbal, physical or sexual harassment.

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[2] Section 36(1) of the *Regulated Health Professions Act, 1991*.

No member shall attempt to influence another member or CMRTO staff with regard to the handling or outcome of a matter with respect to which the member has no direct involvement.

Members shall approach every issue with an open mind and impartially, and without discrimination or favouritism. Members shall foster a collegial work environment and conduct themselves in a manner that demonstrates respect for the views and opinions of colleagues.

It is recognized that members have diverse backgrounds, skills and experience. Members will not always agree with one another on all issues. All debates shall be conducted in a respectful and civil manner.

The authority of the President of Council and the chairs of the committees must be respected by all members.

Council and Committee Unity

Members acknowledge that all Council and committee actions and decisions must be supported by all members. The Council and committees speak with one voice. Those members who have abstained or voted against a motion must adhere to and support the decision of the Council or committee.[3]

Meeting Conduct

Each member agrees to:

1. Attend the meetings, workshops or educational sessions of Council and/or the committees to which they are appointed, and be punctual

2. Notify the Registrar & CEO or staff support person in a timely fashion, in writing or otherwise, if the member is unable to attend a Council or committee meeting and provide a reason for the absence

3. Prepare for each meeting by reading the agenda material prior to the meeting

4. State their position and perspective on issues in a clear and respectful manner

5. Engage constructively in the discussions

6. Where the views of the member differ from that of the majority, engage collaboratively to determine whether a consensus can be reached

7. Pay full attention to the meeting business – avoiding side-bar conversations, taking of phone calls, checking of email on mobile devices, reading of unrelated material, etc.

[3] There may be circumstances where it is appropriate for a member of a statutory committee who disagrees with the majority decision to write a dissent.

8. Refrain from speaking when others are speaking and wait to be recognized by the Chair before speaking

9. Be respectful of others

10. Be respectful of the authority of the President or Chair of the committee

11. Respect the boundaries between members and CMRTO staff, recognizing that CMRTO staff do not work for, or report to, individual members

12. Participate fully in any evaluation processes or continuous quality improvement processes

Acknowledgement

Each member must adhere to this Code of Conduct and commit to support the CMRTO's standards set out in applicable legislation, policies and guidelines.

Each member will review and affirm their commitment to and compliance with the CMRTO's Code of Conduct at the commencement of the member's term of office, and thereafter when there are any changes to this Code of Conduct.

CIRCULATED WITH AGENDA

OF DEC 0 7 2018

COUNCIL ITEM# 4b iii

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Report

To: Council

From: Linda Gough, Registrar & CEO **Date:** November 25, 2018

Subject: Council Composition

This agenda item is for:

- [X] Decision
- [ ] Direction to staff
- [ ] Discussion
- [ ] Information

As all Council members are aware, there was a break in Janice Hoover's appointment to the CMRTO Council following the election of the new government.

Janice's term expired on August 24, 2018 and she was reappointed for 'no more than a one year period', effective November 14, 2018. At the last meeting of Council, Martin Ward was appointed as the Chair of the Registration Committee to fill the vacancy created by the expiration of Janice's term on Council.

Martin has chaired three days of Registration Committee meetings during this period, and is appointed to all the panels currently reviewing applications from internationally educated medical radiation technologists and also diagnostic medical sonographers There are currently 295 applications referred to the Registration Committee.

The Registration Committee is currently focused on making some time sensitive decisions for internationally educated diagnostic medical sonographers(DMSs) who were not practising on December 31, 2017 and so are not eligible for the grandparenting provision of the registration regulation. These applicants were hired as DMSs during 2018 and must be registered by the end of the year to be able to continue to practise effective January 1, 2019.

We very much appreciate and thank Martin for assisting in the work of the Registration Committee at this critical time. Now that Janice is reappointed and ready to resume her past role as Chair of the Registration Committee, Martin has agreed to remain on the Registration Committee to assist with the review of the large volume of applications at the year end, and into 2019. Again, we thank Martin and Janice for their commitment to serving the public of Ontario through reviewing the applications for registration referred to the Registration Committee.

Action required: Council to make a motion to appoint Janice Hoover and Martin Ward to the Registration Committee, to remove Martin Ward as the Chair and to appoint Janice Hoover as the Chair.

Minutes

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Meeting of Council

Tuesday, September 18, 2018
0900 hours — 1600 hours
CMRTO Council Room

Present:	Wendy Rabbie, President Ebenezer Adiyiah Susan Allen Nathalie Bolduc Elaine Bremer Angela Cashell Mary (Susan) Gosso Ray Lappalainen, transitional Council member Jay Neadles Cathryne Palmer, until 1300hrs Janet Scherer Scott Tracze Carolyn Trottier, transitional Council member, until 1300hrs Martin Ward Sandra Willson
Regrets:	Franklin Lyons
Staff:	Linda Gough, Registrar & CEO Caroline Morris, Deputy Registrar Tina Langlois, Director of Professional Conduct & Internal Legal Counsel Annette Hornby, Director of Quality Assurance Nerissa de Vera, Finance & HR Manager, for agenda item 4 Jef Ekins, Communications Coordinator Elizabeth Urso, Manager of Professional Conduct and Policy Kirusha Kobindarajah, Executive Administrator
Observers:	Janet Maggio, Manager of Quality Assurance Kristina Muscat, Policy Analyst, Regulatory Oversight and Performance Unit, MOHLTC Sidsel Pedersen, MRT(R), Instructor, Southern Alberta Institute of Technology Tina White, Manager of Professional Practice

1. Call to Order

The meeting was called to order by W. Rabbie, President at 0900 hours.

a. Approval of the agenda

The agenda and supporting documents were circulated to the Council members earlier.

It was moved by A. Cashell
Seconded by S. Willson

Resolved that the agenda be approved as circulated.

Carried.

b. Review of Roles & Responsibilities of Council

The following documents were circulated on pages 1 – 10 of the agenda:

i. CMRTO Governance Policy 2.11, Roles & Responsibilities of the Council, effective date June 19, 2014, last reviewed September 2017

ii. CMRTO Governance Policy 2.12, Code of Conduct for Council and Committee Members, effective date September 23, 2014, last reviewed September 2017

W. Rabbie briefly reviewed the documents with Council members.

2. Declaration of Conflict of Interest

There were no conflicts of interest declared.

3. Minutes of the previous meeting

a. June 14 & 15, 2018

The following was circulated on pages 11 – 37 of the agenda:

i. Minutes of the meeting of Council held on June 14 & 15, 2018

The following correction was made to the minutes:

- Page 1 third line: Change '<u>June 18</u>', to '<u>June 15</u>'

It was moved by M. Ward
Seconded by E. Bremer

Resolved that the minutes of the Council meeting of June 14 & 15, 2018, be approved as amended.

Carried.

L. Gough reviewed the action items with Council.

4. Financial

Nerissa de Vera joined the meeting for the agenda items pertaining to the financial affairs of the College.

a. Finance & Audit Committee Report

The following was circulated on pages 38 – 41 of the agenda:

i. Report to Council from J. Neadles, Chair, Finance and Audit Committee, dated August 28, 2018, regarding 'Report from Finance and Audit Committee'

ii. CMRTO Governance Policy 2.8, Terms of Reference for the Finance and Audit Committee, effective date June 19, 2014, last amended September 26, 2017

J. Neadles, Chair of the Finance & Audit Committee, reviewed the report with Council and responded to questions.

b. Financial Report for Q2 2018

The following was circulated on pages 42 – 52 of the agenda:

i. Report to Council from the Finance and Audit Committee, dated August 28, 2018 regarding 'Financial Report to Council for Q2 2018 (April 1 – June 30, 2018)', with the following attachments:

- CMRTO Summary of Statement of Revenue & Expenses for the period ending June 30, 2018
- Balance Sheet as at June 30, 2018
- Capital Budget and Expenditures Schedule for the period January 1, 2018 to June 30, 2018
- Cost of Sonography Regulation for the Period Ending June 30, 2018

ii. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Human Resources', with the following attachments:

- CMRTO Organization Chart, last updated: August 2018
- Job posting: Information System Specialist – contract position

J. Neadles reviewed the report with Council and responded to questions.

It was moved by S. Willson
Seconded by E. Adiyiah

Resolved that the report to Council from the Finance and Audit Committee, dated August 28, 2018, regarding 'Financial Report to Council for Q2 2018 (April 1 – June 30, 2018)' and the attached reports:

- **CMRTO Summary of Statement of Revenue and Expenses for the period ending June 30, 2018**
- **CMRTO Balance Sheet as at June 30, 2018**
- **CMRTO Capital Budget and Expenditures Schedule for the period January 1, 2018 to June 30, 2018**
- **Cost of Sonography Regulation for the period ending June 30, 2018**
- **Report from the Registrar & CEO dated September 5, 2018 regarding Human Resources**

be approved.

Carried.

c. Investment Report for Q2 2018

The following was circulated on pages 55 – 56 of the agenda:

i. Report to Council from the Finance and Audit Committee, dated August 28, 2018 regarding 'Investment Report to Council for Q2 2018 (April 1 – June 30, 2018)', with the following attachments:

- CIBC Wood Gundy, Portfolio Evaluation as of June 30, 2018

J. Neadles reviewed the report with Council and responded to questions.

It was moved by C. Palmer
Seconded by E. Bremer

Resolved that the report to Council from the Finance and Audit Committee, dated August 28, 2018, regarding 'Investment Report to Council for Q2 2018 (April 1 – June 30, 2018)', and the attached report:

- **CIBC Wood Gundy Portfolio Evaluation as of June 30, 2018**

be approved.

Carried.

d. External Financial Auditors

The following was circulated on pages 57 – 65 of the agenda:

i. Briefing note to Council from Jay Neadles, Chair, Finance and Audit Committee, dated September 5, 2018 regarding 'RFP for Financial Auditor'

ii. Project Plan for RFP for Financial Auditors

iii. Letter to the CPA firms invited to bid, from Linda Gough, Registrar & CEO, dated June 18, 2018, regarding 'Request for Proposal – Audit Services'

W. Rabbie reviewed the briefing note from the Chair, Finance and Audit Committee and confirmed that the Finance and Audit Committee has completed its RFP and assessment of the responses from the invited audit firms, and is ready to report on its findings and its recommendation in an in camera session of the meeting.

It was moved by M. Ward
Seconded by N. Bolduc

Resolved that pursuant to Section 7(2)(b) of the Health Professions Procedural Code, the meeting of Council move in camera to receive a report from the Finance & Audit Committee regarding the selection of the CMRTO financial auditor on the basis that financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public.

Carried.

All the observers left the meeting and returned at the conclusion of the discussion of this agenda item.

It was moved by E. Bremer
Seconded by C. Palmer

Whereas:

a. **A Request for Proposal (RFP) for audit services, dated June 18, 2018, was sent to the four firms of Kriens – LaRose LLP, Hilborn LLP, Tator, Rose & Leong, and Kopstick Osher, and**
b. **Three of the invited firms responded to the RFP, and**
c. **The Finance and Audit Selection Committee has reviewed the responses, met with representatives from the three firms, evaluated the responses and provided its recommendation to the Finance and Audit Committee, and**

d. The Finance and Audit Committee has recommended to Council that the firm of Hilborn LLP be appointed as the financial auditors for the fiscal year ending December 31, 2018;

Be it resolved that:

Hilborn LLP Chartered Accountants are hereby appointed auditors of the College to hold office until the time of the holding of the next annual meeting of the Council, unless they are earlier duly removed from office, at a remuneration to be fixed by the Council.

Carried.

N. de Vera left the meeting.

5. Strategic Plan & Report

a. CMRTO Strategic Plan

The following was circulated on pages 66 – 85 of the agenda:

i. CMRTO 2017 – 2021 Strategic Plan, Commitment to Regulatory Excellence, approved by Council December 9, 2016

L. Gough reviewed the document with Council and responded to questions.

b. Balanced Scorecard Report

The following was circulated on page 86 of the agenda:

i. CMRTO Dashboard: Q2 2018

L. Gough reviewed the document with Council and responded to questions. Discussion ensued.

It was moved by A. Cashell
Seconded by N. Bolduc

Resolved that the CMRTO Dashboard Q2 2018, January 1 – June 30, 2018, be published on the CMRTO website.

Carried.

c. CMRTO Communications

The following was circulated on pages 87 – 101 of the agenda:

i. Email to CMRTO members, from CMRTO Communications, dated June 14, 2018, regarding Insights Spring 2018, with the following attachment:

- Insights Spring 2018

ii. Email to CMRTO members, DMS applicants and other key stakeholders from CMRTO Communications, dated August 24, 2018, regarding Insights Summer 2018, with the following attachment:

- Insights Summer 2018

L. Gough reviewed the documents with Council and responded to questions. Discussion ensued.

6. For Decision

a. Public Members

The following was circulated on page 102 of the agenda:

i. Briefing note to Council from Linda Gough, dated September 5, 2018, regarding 'Public members'

W. Rabbie reviewed the document with Council and responded to questions.

It was moved by C. Palmer
Seconded by S. Willson

Whereas:

A. On August 24, 2018, the Order in Council for Janice Hoover, a member of Council appointed by the Lieutenant-Governor in Council, expired, leaving the position of Chair of the Registration Committee vacant as of that date;

B. It is anticipated that Janice Hoover will be re-appointed as a member of Council by the Lieutenant-Governor in Council; and

C. Martin Ward, a member of Council appointed by the Lieutenant-Governor in Council, has volunteered to assume the position of Chair of the Registration Committee on an interim basis, until such a time as Janice Hoover is re-appointed as a member of Council by the Lieutenant-Governor in Council.

Be it resolved that:

1. Martin Ward is appointed to the position of Chair of the Registration Committee effective immediately.

Carried.

b. By-law No. 60

The following was circulated on pages 102 – 212 of the agenda:

i. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Consultation Regarding Proposed By-law No. 60'

ii. Eblast sent to CMRTO members, sonography applicants and stakeholders, from CMRTO communications, dated July 9, 2018 regarding Proposed By-law No. 60

iii. Eblast sent to CMRTO members, sonography applicants and stakeholders, from CMRTO communications, dated August 2, 2018 regarding 'We'd like your comments: College of Medical Radiation Technologists of Ontario Proposed By-law No. 60'

iv. Eblast sent to CMRTO members, sonography applicants and stakeholders, from CMRTO communications, dated August 30, 2018 regarding 'Your feedback is required: College of Medical Radiation Technologists of Ontario Proposed By-law No. 60'

v. Text posted to the consultation section of CMRTO website, with the following attachment:

- Proposed changes and additions to proposed By-law No. 60

vi. Summary of comments received to September 5, 2018 respecting proposed By-law No. 60

vii. Detail of stakeholder and member comments received respecting By-law No.60 (circulation period: July 9, 2018 – September 7, 2018), dated September 5, 2018

viii. Briefing note to Council from Tina Langlois, Director of Professional Conduct & Internal Counsel, dated September 5, 2018, regarding 'Proposed revisions to By-law 60'

ix. Proposed By-law No. 60 with track changes, dated July 6, 2018

x. Proposed By-law No. 60, dated September 5, 2018

The following was circulated at the meeting:

xi. Summary of comments received to September 7, 2018 respecting proposed By-law No. 60 (Circulation Period: July 9, 2018 – September 7, 2018), date September 10, 2018

xii. Detail of stakeholder and member comments received respecting By-law No.60 (Circulation Period: July 9, 2018 – September 7, 2018), dated September 10, 2018

T. Langlois and E. Urso reviewed the documents with Council and responded to questions. Lengthy discussion ensued.

It was moved by S. Gosso
Seconded by S. Tracze

Whereas:

A. At the meeting of Council held on June 15, 2018, Council approved, for circulation to the members of the College, a draft proposed By-law No. 60 dated May 31, 2018 ("Proposed By-law No. 60") amending the CMRTO's existing by-law framework;

B. On July 9, 2018, the College sent an e-mail to all members of the College and advised them that Proposed By-law No. 60 was being circulated to members of the College, with a link to the Consultations page on the CMRTO website, where the following resources were posted:
   a. Proposed By-law No. 60,
   b. Proposed By-law No. 60: Proposed Changes and Additions, and
   c. A webinar presentation regarding Proposed By-law No. 60;

C. The July 9, 2018 e-mail advised members that they had the opportunity to comment on Proposed By-law No. 60 no later than September 7, 2018;

D. Council has received a report from the Registrar summarizing the comments received by the College on Proposed By-law No. 60;

E. Council has considered the comments on Proposed By-law No. 60 received by the College.

Be it resolved that:

1. Proposed By-law No. 60 as amended be enacted in accordance with the coming into force provisions set out in section 38 of By-law No. 60.

Carried.

c. Policy Review

The following was circulated on pages 213 – 244 of the agenda:

i. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'CMRTO Policy Review'

ii. CMRTO Policy 0.1 – Policy Register and Review Policy, effective date June 19, 2015, last amended March 27, 2019, with proposed updates

iii. CMRTO Administration Policy 1.1 – Customer Service Accessibility Policy, effective date September 23, 2014, last amended September 26, 2017, with proposed updates

iv. CMRTO Administration Policy 1.4 – Policy and Program regarding workplace harassment, effective date March 27, 2015, last amended September 26, 2017, with proposed updates

v. CMRTO Administration Policy 1.5 – Policy and Program regarding violence in the workplace, effective date March 27, 2015, last reviewed September 2017, with proposed updates

E. Urso reviewed the documents with Council and responded to questions.

Amendments were made to certain policies.

It was moved by A. Cashell
Seconded by S. Willson

Resolved that the proposed amendments to the following policies as circulated in the agenda and as reviewed by Council, be approved:

1. **Policy 0.1, Policy Register and Review Policy**
2. **Policy 1.1, Customer Service Accessibility Policy**
3. **Policy 1.4, Policy and Program regarding workplace harassment**
4. **Policy 1.5, Policy and Program regarding violence in the workplace**

Carried.

d. Diagnostic Medical Sonographers

The following was circulated on pages 245 – 255 of the agenda:

i. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Diagnostic Medical Sonographers (DMSs)'

ii. Email to Rachel Gaudreau, Officer/Manager of Research and Socioeconomic Planning for the Ministry of Employment and Social Services, Quebec, from Debbie Tarshis, WeirFoulds LLP, dated June 29, 2018 regarding 'Chapter 7 (Labour Mobility) of the Canadian Free Trade Agreement (CFTA)'

iii. Email communication between Linda Gough, Registrar & CEO and Kristina Muscat, Policy Analyst, Regulatory Oversight and Performance Unit, Health

Workforce Regulatory Oversight Branch, MOHLTC, dated July 27, 2018 regarding 'Notification 706', with the following attachment:

- Ontario – Quebec Regulatory Cooperation, Weekly Report

iv. CMRTO Communications to members, sonography applicants and stakeholders, regarding the regulation of diagnostic medical sonographers: eblast statistics, dated September 5, 2018

The following was circulated at the meeting:

v. Registration & Application Status for Diagnostic Medical Sonography, prepared on September 17, 2018

L. Gough reviewed the documents and responded to questions. Discussion ensued.

e. Office Lease

The following was circulated on page 256 of the agenda:

i. Briefing note to Council from Wendy Rabbie, President, dated September 5, 2018, regarding 'Office Lease'

W. Rabbie reviewed the briefing note and stated that the Executive Committee considered this matter at their meeting held on August 27, 2018 and will report on the matter, in an in camera session of the meeting.

It was moved by S. Willson
Seconded by N. Bolduc

Resolved that pursuant to Section 7(2)(d) of the Health Professions Procedural Code, the meeting of Council move in camera to receive a report from the Executive Committee regarding the office lease on the basis that personal matters or property acquisitions will be discussed.

Carried.

All the observers left the meeting and returned at the conclusion of the discussion for this agenda item.

f. CMRTO Accreditation Surveyors

The following was circulated on page 257 of the agenda:

i. Report to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Roster of CMRTO Accreditation Surveyors'

L. Gough reviewed the document and responded to questions.

g. Draft WYMKA.... performing procedures for medical radiation and imaging technologists

The following was circulated on pages 258 – 275 of the agenda:

i. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Draft What you must know about.... performing procedures for medical radiation and imaging technologists'

ii. Draft what you must know about .... performing procedures for medical radiation and imaging technologists, dated August 30, 2018

L. Gough reviewed the documents and responded to questions. Lengthy discussion ensued.

7. Discussion

a. Ontario Fairness Commissioner

The following was circulated on pages 276 – 369 of the agenda:

i. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Registration Practices Assessment Report'

ii. Email to Linda Gough, Registrar & CEO and Caroline Morris, Deputy Registrar, from Peter Youssef, Compliance Analyst, Office of the Fairness Commissioner dated May 29, 2018, regarding 'OFC Initiation of Cycle 3 Assessment – College of Medical Radiation Technologists of Ontario', with the following attachment:

- Registration Practices: Indicators and Sources, A Companion to the OFC's Registration Practices Assessment Guide, March 2016, Office of the Fairness Commissioner

iii. Fairness Commissioner's Registration Practices Assessment Report, College of Medical Radiation Technologists of Ontario, 2016 – 2018 Assessment Cycle (Cycle 3)

L. Gough reviewed the documents and responded to questions. Discussion ensued.

b. MOHLTC

The following was circulated on pages 370 – 371 of the agenda:

i. Letter to The Honourable Christine Elliott, Minister of Health and Long-Term Care, MOHLTC from Linda Gough, Registrar & CEO, dated July 16, 2018 regarding 2017 CMRTO Annual Report and status update

L. Gough reviewed the documents and responded to questions.

c. IHF Clinical Practice Parameters and Facility Standards for Diagnostic Imaging

The following was circulated on pages 372 – 492 of the agenda:

i. Email to Linda Gough, Registrar & CEO, from IHF-DiagImaging, College of Physicians and Surgeons of Ontario, dated August 22, 2018, regarding 'Updated CPSO IHF Clinical Practice Parameters and Facility Standards for Diagnostic Imaging – July 2018'

ii. CPSO's Independent Health Facilities Clinical Practice Parameters and Facility Standards, Diagnostic Imaging – July 2018

L. Gough reviewed the documents and responded to questions. Discussion ensued.

d. Prenatal Screening Program

The following was circulated on page 493 of the agenda:

i. Letter to Annette Hornby, Director of Quality Assurance, from Shelley Dougan, Manager, Prenatal Screening Program, BORN Ontario, dated July 24, 2018, regarding 'Application for Membership on the Prenatal Screening Program NTQA Working Group'

L. Gough reviewed the documents and responded to questions. Lengthy discussion ensued.

8. Education Session

Sidsel Pedersen, MRT(R) joined the meeting.

The following was circulated on pages 494 – 497 of the agenda:

i. Briefing note to Council from Linda Gough, Registrar & CEO, dated September 5, 2018, regarding 'Education Session'

ii. ACMDTT Newsletter entitled 'Improving Healthcare for Transgender Patients in Diagnostic Imaging Departments', dated Winter 2017, article written by Virginia Sanders, MRT(R) and Sidsel Pedersen, MRT(R)

L. Gough introduced S. Pedersen to the Council. S. Pedersen gave a presentation entitled 'It's the parts that matter', and responded to questions.

L. Gough thanked S. Pedersen for a very informative presentation and S. Pedersen left the meeting.

9. Meeting evaluation

W. Rabbie asked the Council members to complete the meeting evaluation form circulated on pages 498 – 499 of the agenda and to give the completed forms to the CMRTO staff.

10. Termination of Meeting

The meeting was terminated by W. Rabbie, President at 1450 hours.

CIRCULATED WITH AGENDA

OF DEC 0 7 2018

COUNCIL ITEM# 3.a.iv

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Report

To:	Council		
From:	Executive Committee	**Date:**	November 19, 2018
Subject:	Office Lease		

This agenda item is for:

- [ ] Decision
- [ ] Direction to staff
- [x] Discussion
- [x] Information

In accordance with the direction of the Executive Committee and Council, Jim O'Reilly has negotiated with Manulife regarding an extension of the CMRTO's current lease. The Executive Committee has accepted a Proposal to Lease for a ten-year extension, that is within the criteria set by Council during the in camera session held at the September 18, 2018 meeting.

The Proposal to Lease contains a Tenant's Condition to have approval of the terms of the Proposal to Lease by the CMRTO's senior management and Executive Committee. The Executive Committee reviewed the Proposal to Lease and was satisfied that it was within the criteria approved by Council, then waived the Tenant's Condition and the Landlord prepared the Lease Amending Agreement which amend the terms of the existing lease and the rent amount for the next ten years. All other terms and conditions of the existing office lease remain in full force and effect. CMRTO's internal legal counsel reviewed the Lease Amending Agreement prior to execution by the President and Registrar.

Further details on the terms of the lease extension will be provided in an in camera session of the meeting.

CIRCULATED WITH AGENDA

OF DEC 0 7 2018

COUNCIL ITEM# 4ai

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Report

To:	Council	**Meeting Date:**	December 7, 2018
From:	Jay Neadles, Chair, Finance & Audit Committee	**Date:**	November 7, 2018
Subject:	Report from Finance & Audit Committee		

Since the last meeting of Council, the Finance & Audit Committee met on the following date:

- November 7, 2018

In addition to reviewing the CMRTO's financial reports and investment reports, the Committee has engaged in the following activities:

- Met with Blair MacKenzie, Hilborn LLP, and reviewed and approved the audit planning report for the 2018 financial year
- Reviewed the proposed 2019 budget and 2019 – 2021 financial plan. These items are referred to Council with a recommendation for approval and are included in this agenda material

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Finance and Audit Committee

Policy 2.8

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	September 26, 2017	**Next Review Date:**	September 2020

Policy: Terms of Reference for the Finance and Audit Committee

Purpose

The role of the Finance and Audit Committee of the College of Medical Radiation Technologists of Ontario (CMRTO) is to assist the Council in meeting its financial responsibilities. The Committee shall provide guidance to Council on financial matters as required.

Responsibilities:

It is the responsibility of the Finance and Audit Committee to consider and make recommendations to the Council on the following matters:

Policies

1. Major policies governing financial, budgetary and investment matters
2. The accounting policies to be followed in the preparation of annual financial statements
3. Policies relating to discretionary expenditures, travel and expense accounts, credit cards and other benefits, including the use of corporate assets

Resource Planning

4. The three-year financial projection and annual budget
5. The appropriate level of unrestricted net assets balance to be maintained at year end

6. The annual fee to be paid by members, and other fees set out in the College's by-laws as the Council directs

7. The long-term commitments to be assumed

Financial Performance Monitoring

8. The results of quarterly financial performance relative to approved annual budget

Financial Reporting and Audit

9. The adequacy of a system of internal controls established by management to support financial risk management

10. The quality of annual financial statements relative to approved Council policies

11. The quality of an audit plan developed by the external auditors, the results of the audit contained in the opinion, and response to any items identified in the audit management letter

12. The nature and quality of any financial information provided to external stakeholders

Investments

13. The investment strategy to be adopted, at a minimum of every three years, or as directed by Council

14. The quality of investment proposal(s) from financial advisors on the investment of surplus funds in accordance with established investment policies

15. The quarterly and annual performance of the investment portfolio in the context of approved investment strategy and policies

Other

16. Any other responsibilities as determined by the Council, from time to time

Meeting Frequency

The Committee meets approximately four times per year.

Composition

A minimum of four (4) Councillors shall serve on the Finance and Audit Committee including at least one (1) Councillor appointed by the Lieutenant Governor in Council (public member). Other persons may be appointed to the Committee. The majority of members may be Executive

Committee members. Council will appoint the Chair of the Committee and that person shall not be the President of the Council.

A majority of the members of the Finance and Audit Committee shall constitute a quorum.

The Registrar & CEO shall attend all meetings of the Committee except for meetings or portions thereof dealing with matters with respect to which the Registrar & CEO has a conflict of interest.

CIRCULATED WITH AGENDA

OF DEC 0 7 2018

COUNCIL ITEM# 4b i

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Report

To:	Council	**Meeting:**	December 7, 2018
From:	Finance and Audit Committee	**Date:**	November 7, 2018
Subject:	Financial Report to Council for Q3 2018 (July 1, 2018 – September 30, 2018)		

The Finance and Audit Committee has reviewed the attached annual financial performance reports for the quarter ending September 30, 2018 and is pleased to highlight the following matters for the CMRTO Council:

1. A budget for sonography regulation has been set up as part of the 2018 budget approved by Council in December 2017. An updated report on the Cost of Sonography Regulation is included.

2. The year end forecasted variances in excess of 5% of the approved budget were identified. Management provided the Committee with the causes and effects of the variances and these are provided to the Council as information.

Revenue

Revenue is forecasted with a 7% favourable variance due primarily to sonography application fees being 36% higher than planned. The plan includes 3,000 sonography applications and the forecasted number is 4,100 sonography applications.

Expenses

1. **Human Resources: -3.2% unfavourable variance**
   The Human Resources expense group is forecasted to have an unfavourable variance of 3%. The forecasted variance is due to temporary staff and overtime to address sonography volume, and a new position – Information Systems Specialist.

2. **Operating Expenses: 5.6% favourable variance**
   The Operating Expenses expense group is forecasted to have a favourable variance of 5.6% due to savings from postage, insurance deferral, travel, IT & consulting fees.

3. **Communication & Legal Fees: 32.8% favourable variance**
   The Communication & Legal Fees expense group is forecasted to have a favourable variance of 33%. The anticipated savings is due to expenses such as hearing & investigations, and publications & communications costs being less than planned. The change to electronic communications and publications has reduced costs considerably.

4. **Education, QA & Other Expenses: 32.9% favourable variance**
   The Education, QA & Other Expenses expense group is forecasted to have a favourable variance of 33%. There is no claim expected from the compensation fund and savings from QA assessments and education fund are expected.

Conclusion

At the end of the third quarter of 2018, the CMRTO's planned activities and projects are progressing well with a forecasted increase in revenue of 7% due to more sonography applications. The total expenses before depreciation are forecasted to have a favourable variance of 10%. The Statement of Revenue and Expenses shows an excess revenue of $58,866 as compared to a budget deficit of $671,435.

College of Medical Radiation Technologists of Ontario

Statement of Revenue and Expenses

For The Period Ending September 30, 2018

Variance of <5% does not require explanation

Variances of between 5% and 9% shall be explained detailing the causes of the variances and their effects on the planned activities

Negative variances of 10% and over shall be explained as in the above and may require discussion among Committee or Council members

Positive variances of 10% and over shall be explained as in the above and may require discussion among Committee or Council members

F Favourable
U Unfavourable

	Current YTD	Forecast YTD for Remaining Year	Annual Forecast	Annual Budget	Variance: Annual Forecast vs Annual Budget Bracketed denotes unfavourable variance	Variance %		VARIANCE EXPLANATION
REVENUE:								
Membership-related Revenue	3,115,552	1,654,152	4,769,704	4,451,838	317,866	7.1%	F	Sonography applications more than planned
Revenue - Miscellaneous	431	0	431	0	431		F	Acknowledgement & Undertaking fine
Revenue - Interest Earned	20,309	(309)	20,000	20,000	0	0.0%	F	On plan
Total Revenue:	3,136,292	1,653,843	4,790,135	4,471,838	318,297	7.1%	F	Increase in revenue due to more sonography registration than planned
EXPENSES:								
Human Resources	1,637,298	659,205	2,296,503	2,224,758	(71,745)	-3.2%	U	Variance due to temporary staffing & overtime to address volume of DMS application
Operating Expenses	559,184	308,591	867,775	918,858	51,083	5.6%	F	Savings from postage & courier, insurance, travel, IT & consulting fees
Communication & Legal Fees	455,440	397,342	852,782	1,268,439	415,657	32.8%	F	Expected legal, communications & publications costs less than planned. Electronic communications & publications
Education, Q.A. & Other Expenses	94,088	86,512	180,600	269,300	88,700	32.9%	F	No claim from compensation fund, savings from QA assessments and education
Governance & Committee Expenses	115,799	49,330	165,129	169,925	4,796	2.8%	F	On plan
TOTAL EXPENSES BEFORE DEPRECIATION	2,861,808	1,500,981	4,362,789	4,851,280	488,491	10.1%	F	Savings due to communication & legal, education, QA & other expenses
Depreciation Expenses	234,912	133,568	368,480	291,993	(76,487)	-26.2%	U	Capital costs more than planned
TOTAL EXPENSES AFTER DEPRECIATION	3,096,720	1,634,549	4,731,269	5,143,273	412,004	8.0%	F	
Excess of Revenue over Expenses	39,571	19,295	58,866	(671,435)	730,301			

College of Medical Radiation Technologists of Ontario

Balance Sheet

As At September 30, 2018

	Current YTD	Previous YTD Quarter
ASSETS		
Current Account	447,615	303,714
Charge Card Clearing Account	0	(6,393)
Petty Cash	958	674
Interest Receivable	4,799	2,532
Prepaid Expenses	24,332	33,527
Total current assets	477,703	334,053
Total fixed assets	857,342	927,485
Investments	1,525,552	1,521,091
TOTAL ASSETS	2,860,597	2,782,630
LIABILITIES		
Accounts Payable	0	(19,952)
Accruals	0	40,677
HOOPP Pension Payable	22,131	18,986
HST Receivable	(38,801)	(61,361)
HST Payable	139,819	140,067
Employee tax & RSP deductions	27,733	0
Deferred Revenue *	1,606,547	1,606,547
Deferred Lease Inducement *	56,049	56,049
TOTAL LIABILITIES	1,813,478	1,781,013
EQUITY		
Surplus from Previous Year	1,007,548	1,007,548
Net Income/Loss Year to Date	39,571	(5,931)
TOTAL EQUITY	1,047,119	1,001,617
TOTAL LIABILITIES & EQUITY	2,860,597	2,782,630

* These balances are as at January 1st of the current year and will be adjusted as part of the audit process at year-end

College of Medical Radiation Technologists of Ontario
Capital Budget & Expenditures Schedule
For the Period January 1, 2018 To September 30, 2018

	Current YTD	Forecast Remaining Year	Annual Forecast	Annual Budget	Variance	Variance Explanation
Computer Hardware	5,165	16,135	21,300	54,000	32,700	Purchased computers & equipment for new staff related to sonography; savings on server & tablets for Council/committee meetings deferred to 2019
Computer Software	108,529	137,322	245,851	50,000	(195,851)	Variance due to changes to CMM on SharePoint file structure, creation of pdf notices, fee credit due to bylaw change & fixes made during implementation
Office Equipment	3,122	0	3,122	0	(3,122)	Carry over costs from 2017
Office Renovations	22,029	0	22,029	0	(22,029)	Carry over costs from 2017
Total	**138,844**	**153,458**	**292,302**	**104,000**	**(188,302)**	

College of Medical Radiation Technologists of Ontario
Cost of Sonography Regulation
For the Period Ending September 30, 2018

	Current Month	Current YTD	Variance	Yearly Budget
Capital Expenditures				
Computer Hardware Sonography	0	3,862	9,638	13,500
Computer Software Sonography CMM Online Application	0	68,119	(68,119)	0
Office Equipment	0	3,122	(3,122)	0
Office Renovations Sonography	0	22,029	(22,029)	0
Total Capital Expenditures	**$ -**	**$ 97,131**	**$ (83,631)**	**$ 13,500**
Operating Expenses				
Salaries Sonography	42,297	278,905	232,488	511,393
Outside Services Sonography	399	7,622	(7,622)	0
Printing & Stationery Sonography	0	0	11,000	11,000
Information Technology Sonography	0	5,354	(5,354)	0
Communication & Advertising Sonography	704	28,127	103,873	132,000
Publications & Website Sonography	99	68,456	218,744	265,000
Legal Fees Contingency/Sonography	18,470	65,995	234,005	300,000
Total Operating Expenses	**$ 61,968**	**$ 454,460**	**$ 787,133**	**$ 1,219,393**
Total Sonography Costs	**$ 61,968**	**$ 551,591**	**$ 703,502**	**$ 1,232,893**

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Report

To:	Council	**Meeting:**	December 7, 2018
From:	Finance and Audit Committee	**Date:**	November 7, 2018
Subject:	Investment Report to Council for Quarter 3 2018 (July 1 – September 30, 2018)		

The Finance and Audit Committee has reviewed the attached investment report for the quarter ending September 30, 2018 and is pleased to highlight the following matters for Council:

	Quarter 1 2018	Quarter 2 2018	Quarter 3 2018
Compliance with Investment Policy 4.7 approved December 9, 2014	Yes	Yes	Yes
Interest Earned in each quarter	$5,610	$5,914	$6,384
Interest Earned year to date	$5,610	$11,524	$17,908
Average Rate of Return year to date *	0.33%	0.71%	1.26%
Accrued Interest on Total Portfolio **	$8,094	$2,532	$4,799
Total Portfolio Value including Accrued Interest	$1,617,709	$1,523,623	$1,530,351

* Average Rate of Return year to date = Interest Earned year to date/Average Portfolio Value

** Accrued Interest on Total Portfolio is interest earned but not received yet

PRIVATE WEALTH MANAGEMENT

PORTFOLIO EVALUATION (CAD)

As of September 30, 2018

CIBC WOOD GUNDY

COLLEGE OF MEDICAL RADIATION TECHNOLOGISTS OF ONTARIO (415138742C)

Your Investment Advisor: Bryan Baker
CIBC Wood Gundy

Last Purchase	Quantity	Description	Unit Cost	Book Value	Market Price	Market VL	% of Total	G/L (%)	Unrealized G/L **
Cash & Cash Equivalents									
Cash									
	142	ACCOUNT BALANCE CAD	1.000	142.45	1.000	142.45	0.01		
Securities Expiring Within a Year									
12/22/2014	100,000	MTL TR A 2.32% 22DC18	100.000	100,000.00	100.000	100,000.00	6.56		
07/20/2018	250,000	CIBC TR GIC 2.25% 22JL19	100.000	250,000.00	100.000	250,000.00	16.39		
Total Securities Expiring Within a Year				***$ 350,000.00***		***$ 350,000.00***	***22.94 %***		
High Interest Savings Account									
	102,747.365	BNS TIERED INVST SV(6000)	1.000	102,747.37	1.000	102,747.37	6.74		
07/03/2018	510,669.760	CIBC HIGH INT SVG A(5002)	1.000	510,669.76	1.000	510,669.76	33.47		
09/21/2015	10,270.005	RBC INVST SVG ACCOU(2010)	10.000	102,700.05	10.000	102,700.05	6.73		
01/04/2018	301,344.610	REN HIGH INT SVG AC(5000)	1.000	301,344.01	1.000	301,344.61	19.75		0.60
09/23/2015	5,794.749	TD INVST SVG ACCOUN(8150)	10.000	57,945.15	10.000	57,947.49	3.80		2.34
Total High Interest Savings Account				***$ 1,075,406.33***		***$ 1,075,409.28***	***70.49 %***		***$ 2.94***
Total Cash & Cash Equivalents				***$ 1,425,548.78***		***$ 1,425,551.72***	***93.44 %***		***$ 2.94***
Short-Term									
Guaranteed Investment Certificate									
12/22/2014	100,000	NTL TR A 2.57% 22DC19	100.000	100,000.00	100.000	100,000.00	6.56		
Total Short-Term				***$ 100,000.00***		***$ 100,000.00***	***6.56 %***		
Total				$ 1,525,548.78		$ 1,525,551.72			$ 2.94

Accrued Interest:	$ 4,799
Declared and Unpaid Dividends:	
Total Portfolio Value:	$ 1,530,351

CIRCULATED WITH F4a AGENDA
DATE: NOV 0 7 2018
ITEM # 4bi

** Where applicable, Unrealized G/L includes accumulated interest. Accumulated interest is included in the "Unit Cost" / "Invested Cost" and in the "Book Value" / "Invested Capital" columns.

College of
Medical Radiation
Technologists of
Ontario

Ordre des
technologues en
radiation médicale
de l'Ontario

STRATEGIC PLAN
2017-2021

COMMITMENT TO REGULATORY EXCELLENCE

Approved by Council December 9, 2016

CONTENTS

MISSION

The mission of the CMRTO is to regulate the profession of medical radiation technology to serve and protect the public interest

VALUES

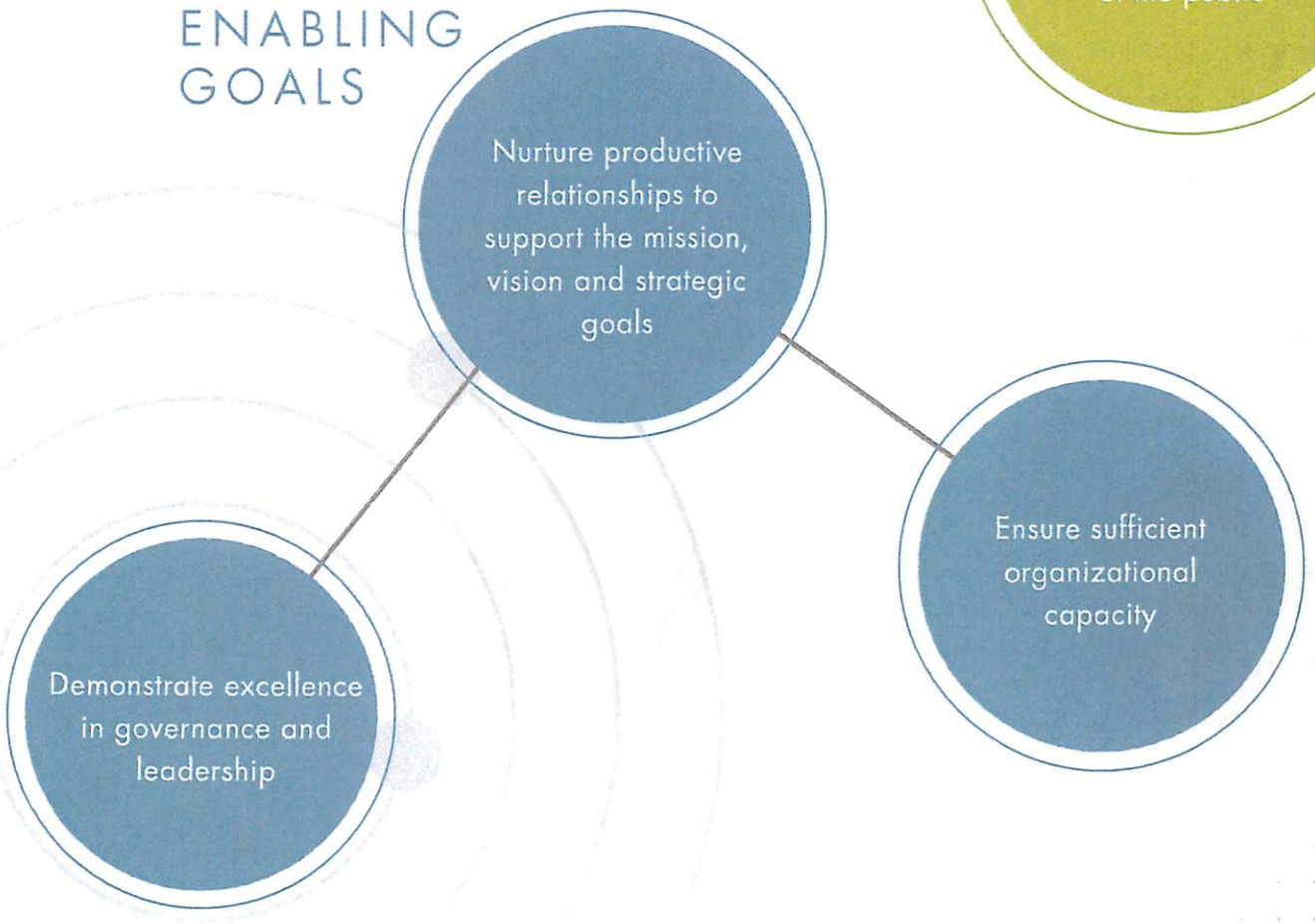
Integrity
—
Fairness
—
Transparency
—
Respect
—
Professionalism

VISION

The CMRTO is a future-focused, responsive, collaborative regulator committed to excellence

STRATEGIC GOALS

ENABLING GOALS



COMMITMENT TO REGULATORY EXCELLENCE

We are pleased to share with you the 2017-2021 Strategic Plan of the College of Medical Radiation Technologists of Ontario (CMRTO). This Plan commits us to the continuing pursuit of excellence and accountability in our public protection mandate. Health regulatory colleges, including the CMRTO, are part of the health care system in Ontario and help to ensure excellence in care delivery. Regulated health professionals, and, in our case, medical radiation technologists (MRTs), are accountable to their health regulatory colleges for the quality of care they provide.

Great change is underway in Ontario's health care system. We are seeing a heightened focus on the patient, new models of care, the relentless pursuit of optimal value for health care dollars spent, and expectations of professionals to continuously improve the delivery of quality health services. Further, the field of medical radiation technology is advancing as innovative technologies are introduced. In the context of all these developments, MRTs will continue to experience change in their workplace environment and be called on to respond.

The Plan presents our roadmap for the next five years. We intend to make progress on our three strategic goals and reinforce our enabling capabilities. Faithful to our vision, mission, and values, we will continue to bring our regulatory lens to support the continuing competence of MRTs in the delivery of safe and effective services in this rapidly changing environment. We will increase our efforts to engage with and be accessible to the public. To help ensure a patient-centred effective health system, we will strengthen the work we do with our valued partners both in fulfilling our important regulatory role and serving as a trusted resource.

We look forward to meeting the challenges set out in this Strategic Plan.

Wendy Rabbie, MRT(R)
President

Linda Gough, MRT(R), MPA
Registrar & CEO

INTRODUCTION

ROLE

The College of Medical Radiation Technologists of Ontario (CMRTO) regulates medical radiation technologists (MRTs) in Ontario. In Ontario, regulated health professions are governed under the *Regulated Health Professions Act, 1991* (RHPA) and health profession Acts (for the CMRTO, *the Medical Radiation Technology Act, 1991*). This legislative framework establishes health regulatory colleges, which regulate the professions in the public interest. Health regulatory colleges are responsible for ensuring that regulated health professionals provide health services in a safe, effective and ethical manner. CMRTO does this by ensuring that MRTs are competent to practice and are practising professionally. Schedule 2 to the RHPA, the *Health Professions Procedural Code*, sets out requirements that ensure that health professional regulation in Ontario is transparent, objective, impartial and fair for those seeking to become regulated health professionals, for the regulated health professionals who are governed by the health regulatory colleges, and in particular, for patients and members of the public.

CMRTO's powers and duties derive from this legislative framework. The CMRTO Council recognizes these obligations as the central mandate of the organization.

GOVERNANCE

The Council is the governing body of the CMRTO. The Council is made up of both members of the public, who are appointed by the provincial government, and members of the profession who are elected from the membership. In addition to the Council, the CMRTO has a number of statutory committees to manage the regulatory activities of the CMRTO. The statutory committees are made up of members of the public who are appointed to the Council, members of the profession who are elected to the Council, and members of the profession who are appointed by the CMRTO Council.

The Council, its committees and management are committed to serve and protect the public interest through progressive, leading-edge governance and regulatory oversight processes.

THIS PLAN

Through the execution of the 2014-2016 Strategic Plan, CMRTO made substantial advancements in innovating and enhancing our regulation in the public interest. We helped facilitate patient-centred care through the development of practice guidelines for MRTs to communicate with patients, provided support to enhance the individual MRT's understanding of their role in self-regulation, and strengthened the profession's contribution to inter-professional teams and quality, safe care. We worked to ensure that the public and stakeholders know what we do through enhanced communications including a new website, electronic communications and social media, and we strengthened our organization and deepened collaboration with our partners.

While the Council felt the previous plan still had resonance, the Council undertook a planning process in the Summer/Fall of 2016. The goal was to step back, review progress, and – considering the environment for MRTs and the organization – renew and refresh the strategic direction of CMRTO identifying where to focus and redouble effort. We reviewed trends, priorities and opportunities for the CMRTO. In a scan of issues external to the organization, Council members reflected on the changes MRTs and the organization face in Ontario's evolving health care system. The senior management team identified changing demands from their perspective and what next steps were called for in certain initiatives underway.

In September 2016, the Council met in a planning session to reflect on the themes from the environment, review the CMRTO's mission, vision and values, and identify the key themes of future priority.

Through robust discussions, Council developed the draft 2017-2021 Strategic Plan. A further session with the Executive Committee and senior staff refined the draft plan. Finally, Council members reviewed the draft and provided further comment.

In December 2016, the Strategic Plan was approved by Council. This Strategic Plan will guide CMRTO through the next five years so that its obligations and mandate continue to be met while recognizing and responding to the rapidly evolving health care environment.

We helped facilitate patient-centred care through the development of practice guidelines for MRTs.

OUR MISSION, VISION AND VALUES

MISSION

Our mission is a statement of organizational purpose and reflects our core mandate as set out in legislation:

The mission of the CMRTO is to regulate the profession of medical radiation technology to serve and protect the public interest.

VISION

Our vision describes our organization as we work toward achieving our goals and our full potential. It inspires our future and shapes our directions:

The CMRTO is a future-focused, responsive, collaborative regulator committed to excellence.

VALUES

Our values shape our organizational culture and drive attitudes and behaviour. We seek to demonstrate these values in our decision-making and actions:

- Integrity
- Fairness
- Transparency
- Respect
- Professionalism

STRATEGIC GOALS

Building on a base of sound regulatory processes, these strategic goals have been set by Council because they are primary to the advancement of the CMRTO's mandate for the years 2017-2021. They focus us on what really matters in the context of our dynamic environment.

1. Ensure MRTs continue to practice safely, effectively and ethically in a changing health care environment

MRTs are part of the substantial changes happening in the province's complex health system. We must continue to uphold the highest expectations for public protection through the effective regulation of MRTs. We will deepen our understanding of how the *Patients First*[1] action plan, new models of care delivery, technological changes, and approaches to quality and efficiency are impacting MRT practice. We will ensure our regulatory framework is sufficiently robust and responding as appropriate with standards, policies and practice guidance. In the changing workplace, MRTs must learn what is necessary to continue to demonstrate professional competence and exercise their knowledge, skills and judgement appropriately. The changes affect both the readiness of new professionals and existing practitioners.

Notable in this next period, given the changing workplace environment and collaborative care priority, it is our intention to focus on MRTs communicating effectively and respectfully with others involved in the provision of health care, appreciating their differing scopes of practice. MRTs must assess and respond to patient needs and expectations; they must be mindful of the patient experience and support it with appropriate communications.

Objectives are:

- Promote patient-centred care and collaborative practice by MRTs including effective communications with patients, their families and other health professionals
- Ensure transparent, objective, impartial and fair entry to practice requirements that provide effective public protection
- Advance the regulatory framework for MRTs relative to evolving technologies and practice
- Ensure MRTs maintain and improve their knowledge, skills and judgement required in changing practice
- Reinforce MRTs' awareness and understanding of their professional responsibilities and accountabilities

2. Enhance the confidence of all stakeholders in the regulation of MRTs

Regulation is about public protection and safety and must be built on a foundation of transparency, performance and accountability.

We will continue to ensure MRTs have the necessary tools to understand and communicate their public protection obligations. More broadly, we know that the public and key stakeholders such as patients, MRTs, employers and other health professionals need access to appropriate information in order to trust that the system of self-regulation works effectively. To strengthen public and stakeholder confidence in what we do, CMRTO will continue to examine and evolve our practices to ensure access by all stakeholders to relevant, credible and accurate information about our priorities and activities.

[1] Patients First is Ontario's plan for changing and improving Ontario's health system. See its Action Plan for health care at http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/

We recognize that our regulatory response can and should be informed by the experience and wisdom of patients, families, caregivers, employers, other health care professionals, and the public. We will ensure we have a good understanding of stakeholder perceptions of CMRTO's accountability and address any gaps. In particular, through mechanisms of deeper engagement, we will seek to listen to the voice of patients and incorporate their perspectives.

Objectives are:

- Engage the public in the effective regulation of MRTs
- Engage MRTs in fulfilling their role in self-regulation
- Support employers in meeting their obligations with respect to the regulation of MRTs
- Enhance understanding among health professionals about the role and regulation of MRTs

3. Contribute and respond to government initiatives to ensure the continued protection of the public

Heightened expectations of public safety, professionalism and accountability are driving public policy shifts. The landscape of regulation and health care policy is being reshaped. The CMRTO must stay current with rapidly responding system-and practice-level challenges and changes as they arise. We will aim to continue to be a trusted resource for government and other system stakeholders by proactively providing perspective and advice in areas related to our expertise, as requested and as appropriate. The CMRTO must respond in a timely and transparent fashion and adjust its work to support government and agency initiatives. In addition, CMRTO must ensure MRTs are aware of and understand the evolving regulatory framework and their obligations, and can gain and exercise the appropriate knowledge, skills and judgement to continue to practise effectively, efficiently and safely.

It is anticipated that the public protection framework will be strengthened through the regulation of diagnostic medical sonographers with CMRTO. This major new responsibility will impact all parts of the organization and its functions. If the CMRTO is directed by the Ministry to assume this responsibility, we will effectively integrate diagnostic medical sonographers into the regulatory framework and amend our practice standards and guidelines as required.

In all these matters, we will work collaboratively and effectively with government, the public, MRTs and relevant stakeholders.

Objectives are:

- Participate in the development of public policy and regulatory innovation in the public interest
- Implement regulatory changes effectively and transparently
- Facilitate the regulation of diagnostic medical sonographers
- Be seen as a valued resource in regulatory change to protect the public

We will continue to ensure MRTs have the necessary tools to understand and communicate their public protection obligations.

ENABLING GOALS

Enabling Goals are the underpinning foundation for achieving the Strategic Goals. They identify critical success factors that must also be achieved over the next period.

4. Demonstrate excellence in governance and leadership

Building on the achievements of our last Strategic Plan, the CMRTO remains committed to strengthening and enhancing the quality of its governance and leadership. We recognize this aspect as critical to our strength and accountability. We will continue to ensure Council and committee members have the necessary resources and education to fulfil their obligations in an ever-changing and complex environment.

We will continue to monitor the effective implementation of the Strategic Plan, and promote a culture of integrity, fairness, transparency, respect, and professionalism. As we are dedicated to measuring and monitoring our effectiveness we will continue to provide relevant performance information in our public and government reports.

Objectives are:

- Maintain the effectiveness of the CMRTO Council and the committees
- Continue the systematic review of governance policies and processes and revise when necessary
- Continue to demonstrate regulatory accountability, performance and compliance

5. Ensure sufficient organizational capacity

The success of the CMRTO's work hinges on a well-aligned and high-performing organization to meet our statutory obligations and deliver on the mission, vision and strategic plan. The CMRTO must have the necessary financial resources, people and facilities to do the work of regulation.

Over the next period, the CMRTO Council will continue to demonstrate responsible stewardship of the organization's finances to maintain financial sustainability. We will strive to maintain the appropriate complement of high-functioning staff in a healthy work environment.

There are increased expectations for health regulatory colleges to facilitate ehealth and enhanced information to the government, its agencies and the public. CMRTO's systems must be robust for new requirements as they emerge while continuing to be utilized and improved to support our strategic goals and operational needs. In this Strategic Plan, we allocate effort to ensuring the continued sufficiency of our information management and technology.

Objectives are:

- Maintain an optimal level of:
  - Finances
  - Human Resources
  - Facilities
- Ensure that our information technology systems and content meet regulatory, operational and strategic requirements

6. Nurture productive relationships to support the mission, vision and strategic goals

A significant enabler of all the strategic goals is the quality of the relationships the CMRTO builds and maintains with stakeholders and other organizations. We believe that collaboration contributes to better outcomes. The CMRTO will continue to foster strong partnerships and work with stakeholders including government and its agencies, the professional associations of MRTs and diagnostic medical sonographers, our peer regulators in other provinces, educational institutions, and others. Working with other organizations informs our efforts, advances our goals and maximizes our potential.

We recognize the on-going initiatives of the provincial government and other stakeholders to transform and restructure the health care system — making it more integrated, accessible, transparent and accountable. Using our insights, expertise and passion for public protection, we will support this wider work as part of Ontario's health care system.

Our objective is to foster effective relationships with stakeholders and organizations, including:

- Ministry of Health and Long-Term Care (MOHLTC)
- HealthForceOntario (HFO)
- Health Quality Ontario (HQO)
- Office of the Fairness Commissioner (OFC)
- Federation of Health Regulatory Colleges of Ontario (FHRCO)
- Alliance of Medical Radiation Technologists Regulators of Canada (AMRTRC)
- Ontario Association of Medical Radiation Sciences (OAMRS)
- Canadian Association of Medical Radiation Technologists (CAMRT)
- Ontario Association of Radiology Managers (OARM)
- Sonography Canada
- Other professional associations
- Other regulators
- Educational institutions
- Employer groups
- Other organizations, agencies, and service providers

We recognize the on-going initiatives of the provincial government and other stakeholders to transform and restructure the health care system...

CONCLUSION

Our past achievements demonstrate that the CMRTO is already a highly effective, responsive and collaborative regulator.

This Strategic Plan sets out the roadmap for an exciting journey and the CMRTO Council is committed to ensuring the execution of the plan. The Council has directed staff to develop annual operating plans articulating strategies and tactics to implement the Strategic Goals and their objectives.

The Council will review this 2017-2021 Strategic Plan annually and update it as necessary given developments internally and externally.

APPENDIX A: Environmental Scan

These themes, amongst others, informed the Council's planning and shaped the directions of the Strategic Plan.

Patients First

The Ministry of Health and Long Term Care (MOHLTC) is continuing to transform and restructure the health care system — making it more integrated, accessible, transparent and accountable. Its "Patients First" action plan contemplates fundamental changes to the system to address the disparate way different health services are planned and managed. On December 7, 2016, the Ontario Legislature passed Bill 41, the *Patients First Act*. This legislation proposes a reorganization of Ontario's health care system, with a strengthened role and mandate for Ontario's 14 Local Health Integration Networks.

Radiation Protection Legislation

In July 2016 Health Quality Ontario (HQO) issued its *Report and Recommendations of Modernizing Ontario's Radiation Protection Legislation* which made recommendations regarding expanding the scope of legislation for radiation protection in Ontario to include all energy-applying medical devices and introducing modernized legislation, regulation, and accountability mechanisms. The government is currently considering the recommendations which would require legislative and organizational changes. Changes to this legislation will impact most MRTs in Ontario.

Independent Health Facilities Regulation

The 2015 data from the Canadian Institute of Health Information (CIHI) indicates that 15% of the CMRTO members are employed in Independent Health Facilities. Any changes in this sector will directly affect those members. In 2016, HQO issued its report *Building an Integrated System for Quality Oversight in Ontario's Non-Hospital Medical Clinics* which made thirteen broad recommendations. One major recommendation was that the Independent Health Facilities and Out-of-Hospital Premises quality programs should be consolidated into a single regulatory model that can easily encompass procedures not currently regulated in existing programs. The government is currently considering the recommendations which would require legislative and organizational changes to the current system.

Regulated Health Professions Act (RHPA)

MOHLTC continues to press forward with its transparency initiative which may include amendments to the RHPA directing what information health regulatory colleges must make available on their pubic registers and websites. The *Sexual Abuse Task Force (SATF) Report* also recommends changes to the RHPA structure. The government is expected to act in response and has already indicated their intention to introduce an initial set of amendments to the RHPA in the fall of 2016.

Health Information Protection Act

Bill 119, the *Health Information Protection Act*, received Royal Assent in May 2016. It was aimed at protecting patient privacy and improving transparency. The Act amends two key pieces of legislation, the *Personal Health*

Information Protection Act (PHIPA) and the *Quality of Care Information Protection Act (QCIPA)*. Changes now require organizations to report to the relevant health regulatory colleges if there is believed to be professional misconduct, or if the health practitioner in question is incompetent or incapacitated. There is also the requirement to alert the relevant health colleges in cases where an employee or agent of a health information custodian is terminated, suspended or subject to disciplinary action arising out of unauthorized collection, use, disclosure and other privacy infringements.

Bill 119 also allows the MOHLTC to prescribe by regulation the information that health regulatory colleges are required to obtain from their members and provide to MOHLTC in order to facilitate ehealth. The full implementation of ehealth will rely on regulatory colleges' member data and information.

The proposed regulation of diagnostic medical sonographers

Diagnostic medical sonographers are health care practitioners who use soundwaves for diagnostic ultrasound to produce diagnostic images of the body. Diagnostic medical sonographers are not regulated and under the Controlled Acts regulation of the RHPA, any person is authorized to apply soundwaves for diagnostic ultrasound provided the procedure is ordered by an authorized health practitioner. This is a serious gap in the public protection framework for diagnostic imaging, and the position of the CMRTO Council is that it is in the public interest to regulate diagnostic medical sonographers with CMRTO under the RHPA.

In September 2000, the Health Professions Regulatory Advisory Council (HPRAC) recommended to the Minister of Health and Long Term-Care that diagnostic sonographers be regulated under the RHPA and as part of the profession of medical radiation technology governed by the CMRTO. In July 2008, the Minister of Health and Long-Term Care requested HPRAC to make recommendations on the currency of, and any additions to, advice provided in relation to the regulation of diagnostic sonographers. The HPRAC report was released in August 2015 and recommends that diagnostic medical sonographers be regulated with CMRTO as a fifth specialty.

CMRTO Council approved the formation of a Sonography Implementation Group (SIG) to advise Council on the required amendments should the government decide to regulate diagnostic medical sonographers with CMRTO. SIG met five times in early 2016, and developed 27 recommendations for amendments to the MRT Act, the registration, quality assurance and professional misconduct regulations, the CMRTO standards of practice and other policies, should the government decide to regulate diagnostic medical sonographers with CMRTO. The 27 recommendations were presented to the CMRTO Council in June 2016, and Council released a public statement supporting the proposed regulation of diagnostic medical sonographers in the public interest.

In September 2016, the recommendations of the Sexual Abuse Task Force (appointed by the Minister of Health and Long-Term Care to provide advice on strengthening the sexual abuse provision of the RHPA), were released. These recommendations include one that states that diagnostic medical sonographers should be regulated under the RHPA with an existing college.

The CMRTO continues to work with the Ministry of Health and Long-Term Care, professional associations, and diagnostic medical sonographers to support and implement the regulation of diagnostic medical sonographers with CMRTO, should the government decide to act on the advice provided by HPRAC and the Sexual Abuse Task Force.

Technological advances in diagnostic and therapeutic equipment

Therapeutic and diagnostic imaging technology is rapidly evolving. As recognized in the environmental scan done prior to the last strategic plan, developments in hybrid technologies are requiring MRTs who have previously specialized in one modality to operate in an additional modality. Other technological advancements are happening too. MRTs at all stages of their professional career must have the requisite knowledge, skills and judgement to use these advances in equipment safely.

The changing workplace

Optimizing utilization of health human resources has been a consistent theme over the last decade. The result has been a real focus on "lean" and finding efficiencies as well as leveraging and optimizing health care teams. Providers of health care must work together to provide and improve health care services in the best interests of the public. Yet, their effectiveness depends greatly on the team members' knowledge of one another's roles and scopes of practice, mutual respect, willingness to cooperate and collaborate, and organizational supports. MRTs are part of the interprofessional care team, where work processes are changing including the "who does what." It is becoming important to understanding other health professionals and their scope. MRTs must be able to function and exercise the knowledge, skills and judgement to successfully adapt to changes in health care delivery models.

Increasing patient expectations of health care and health professionals

As noted three years ago in the environmental scan, patients and their families may know a great deal about the tests and treatments being performed and the technology to be used. In the health care system today, there is an increased focus on the patient's experience, and making the patient a central member of the team. Patients and their families expect to be listened to and receive timely, accurate and complete information that will help empower them about their own care. MRTs must be able to provide appropriate responses to patient inquiries about procedures and related issues in an increasingly complex and multi-cultural health care delivery setting.

Professional accountability and transparency

The public is engaged and interested to the health system's performance. Health professionals and their regulatory colleges continue to experience an increased demand for strong oversight and accountability as well as transparency. Health colleges must make responsibilities clear for their members and provide mechanisms to hold members to account. In addition, regulators must facilitate the public having easy access to accurate and relevant information so that patients are confident that there are vigorous regulatory processes designed to protect them.

NOTES

College of
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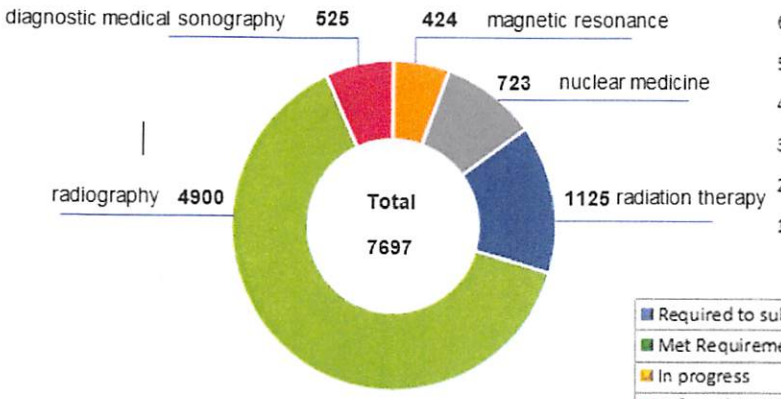
Fax: 416.975.4355
www.cmrto.org

CMRTO Dashboard Q3 2018: January 1 - September 30, 2018

Active members by primary specialty



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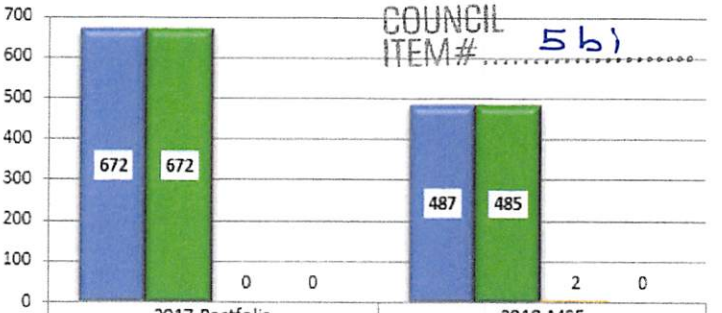
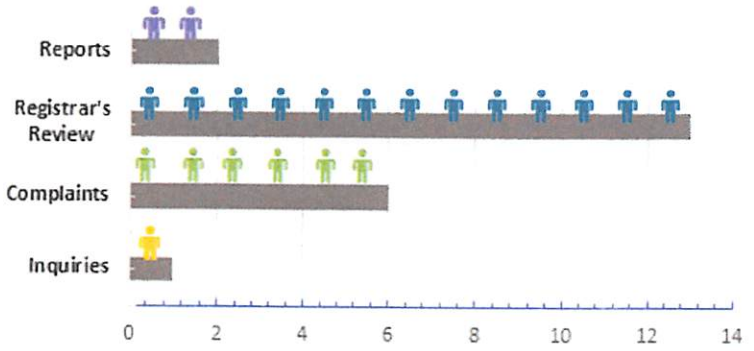
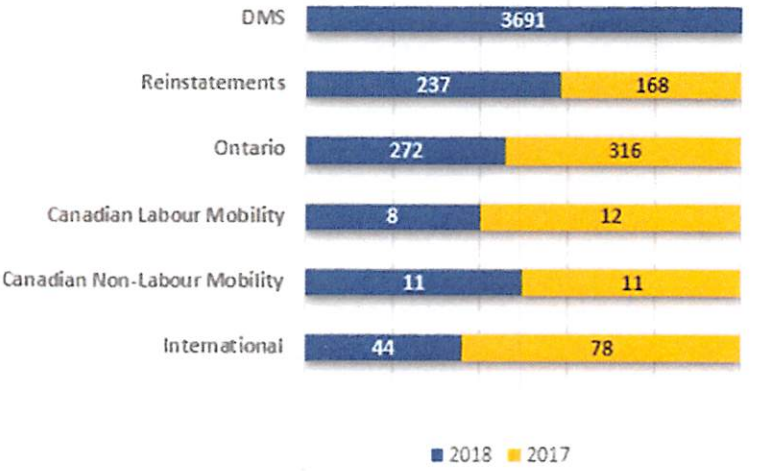


	2017 Portfolio	2018 MSF
Required to submit	672	487
Met Requirements	672	485
In progress	0	2
Referred to ICRC	0	0

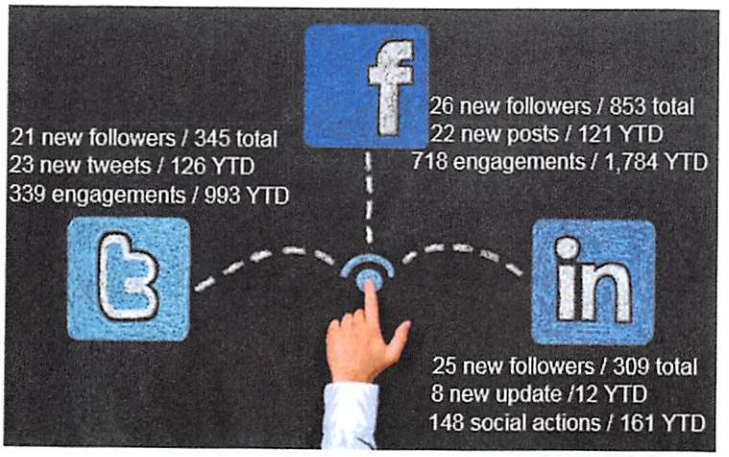
Professional Conduct New Cases



Registration Applications



Communications



23 Presentations
to members & applicants
1175 attendees

6 Conference exhibits
332 booth visits

14 Meetings
with government & agencies

Kirusha Kobindarajah

From: CMRTO Communications <communications@cmrto.org>
Sent: October-02-18 3:56 PM
To: Jef Ekins <jef.ekins@cmrto.org>
Subject: CMRTO Electoral District Changes

Hello CMRTO members and applicants:

Effective October 1, 2018, the CMRTO electoral districts changed to include our new specialty of diagnostic medical sonography. In addition, the previous four geographical districts for the specialty of radiography have been consolidated into one: District One. The table of the new districts is set out below.

Previous Districts	New Districts - effective October 1, 2018	Next election date	Current elected member
1. Radiography - Northern	1. Radiography	April 2021	Wendy Rabbie, MRT(R)
2. Radiography - Eastern			
3. Radiography - Central			
4. Radiography - Western			
5. Radiation Therapy	2. Radiation Therapy	April 2021	Angela Cashell, MRT(T)
6. Nuclear Medicine	3. Nuclear Medicine	April 2020	Sandra Wilson, MRT(N)
8. Magnetic Resonance	4. Magnetic Resonance	April 2019	Jay Neadles, MRT(R)(MR)
	5. Diagnostic Medical Sonography	April 2019	New district
	6. Member-at-large	April 2019	New district
7. Faculty member	7. Academic member	Becomes an elected position	Cathryne Palmer, MRT(T)

The current members of Council who were elected in the retired electoral districts of radiography based on the geographical regions of Eastern, Central and Western, will complete their current terms: Nathalie Bolduc until June 2019; Ebenezer Adiyiah until June 2020; and Janet Scherer until June 2019. The terms of the two transitional Council members in the specialty of diagnostic medical sonography, Carolyn Trottier and Ray Lappalainen, will end in June 2019.

Your CMRTO Member Profile has been updated with your new electoral district, based on your specialty certificate of registration. For those members who are registered in more than one specialty, your electoral district has been assigned based on your primary specialty. All CMRTO members will be eligible to run for election and to vote in District 6, Member-at-large.

Further information on the election process can be found here, current elections here, and the Council composition here.

The notice of the April 2019 election for the three districts will be published in the Fall 2018 edition of the CMRTO newsletter, Insights, and emailed to all CMRTO members.

Thank you.

Linda Gough
Registrar & CEO

College of Medical Radiation Technologists of Ontario
375 University Avenue, Suite 300
Toronto, Ontario, M5G 2J5
tel 416.975.4353 1.800.563.5847
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email communications@cmrto.org
www.cmrto.org

Have any questions about this email? Contact communications@cmrto.org

Kirusha Kobindarajah

From: CMRTO Communications <communications@cmrto.org>
Sent: October-22-18 12:10 PM
To: Jef Ekins <jef.ekins@cmrto.org>
Subject: [TEST]: Insights - Fall 2018

The CMRTO is pleased to announce that the Fall 2018 issue of *Insights* is now available. Please click here to read or download a PDF version of this issue, or click here to view this issue on our website.

In this issue, we talk about:

- CMRTO's new electoral districts
- Notice of election
- Upcoming webinars
- The latest update about the regulation of diagnostic medical sonographers
- Information sessions in Ajax, Ottawa, Thunder Bay, Toronto, Hamilton, Sudbury, Brampton and London
- What you must know about ... performing procedures for medical radiation and imaging technologists
- New Quality Assurance Manager and Professional Practice Advisor

Click here to read *Insights* now.

Thank you,

CMRTO Communications

College of Medical Radiation Technologists of Ontario
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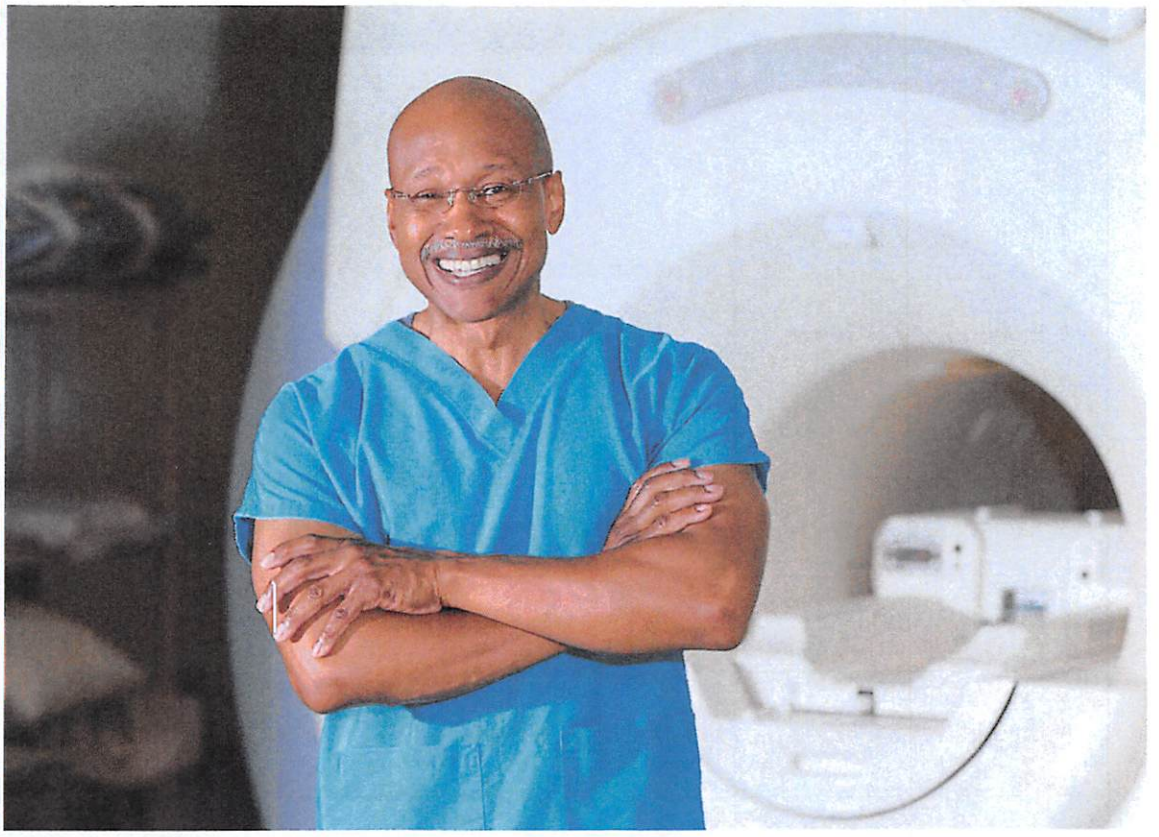
INSIGHTS



IN THIS ISSUE:

New electoral districts

Effective October 1, 2018, the CMRTO electoral districts changed to include our new specialty of diagnostic medical sonography. In addition, the previous four geographical districts for the specialty of radiography have been consolidated into one: District One. The table of the new districts is set out below.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Previous districts	New districts – effective October 1, 2018	Next election date	Current elected member
1. Radiography - Northern	1. Radiography	April 2021	Wendy Rabbie, MRT(R)
2. Radiography - Eastern			
3. Radiography - Central			
4. Radiography - Western			
5. Radiation Therapy	2. Radiation Therapy	April 2021	Angela Cashell, MRT(T)
6. Nuclear Medicine	3. Nuclear Medicine	April 2020	Sandra Willson, MRT(N)
8. Magnetic Resonance	4. Magnetic Resonance	April 2019	Jay Neadles, MRT(R) (MR)
	5. Diagnostic Medical Sonography	April 2019	New district
	6. Member-at-large	April 2019	New district
7. Faculty member	7. Academic member	Becomes an appointed position	Cathryne Palmer, MRT(T)

The current members of Council who were elected in the retired electoral districts of radiography based on the geographical regions of Northern, Central and Western will complete their terms: Nathalie Bolduc until June 2019; Ebenezer Adiyiah until June 2020; and Janet Scherer until June 2019. The terms of the two transitional Council members in the specialty of diagnostic medical sonography, Carolyn Trottier and Ray Lappalainen, will end in June 2019, following the election of a DMS in District 5.

Your CMRTO Member Profile has been updated with your new electoral district, based on your specialty certificate of registration. For those members who are registered in more than one specialty, your electoral district has been assigned based on your primary specialty. All CMRTO members will be eligible to run for election and vote in District 6, member-at-large.

Further information on the election process can be found here, current elections here and the Council composition here.

Notice of Election

CMRTO will hold elections in Districts 4 (Magnetic Resonance), 5 (Diagnostic Medical Sonography) and 6 (Member-at-large) on April 3, 2019.

All CMRTO members will be sent an email on November 29, 2018 outlining the election process and the electoral districts you are eligible to vote in. Since this is the first election to be held for the new member-at-large Council seat, all CMRTO members will be able to vote in this election and will therefore receive an email with additional details about the upcoming elections.

Nominating forms giving all eligible members the opportunity to stand for election in 2019 will be emailed on December 4, 2018.

For more information about the CMRTO Council, please click here. For more information about the election process or the new electoral districts, please click here.

What you must know about ... performing procedures for medical radiation and imaging technologists

At the CMRTO Council meeting on September 18th, Council reviewed the second draft of "What you must know about ... performing procedures for medical radiation and imaging technologists" for electronic publication and distribution to all CMRTO members.

This publication outlines the information that CMRTO members must know and understand regarding the performance of medical radiation and imaging technology procedures in accordance with the Standards of Practice. This includes:

- performing procedures within the scope of practice of the profession,
- having the knowledge, skills and judgment to perform a procedure, and
- ensuring that the appropriate order authorizing the performance of a procedure, treatment or intervention is in place prior to performing the procedure, treatment or intervention.

These requirements are discussed in detail in Part I of the publication, which also includes a summary of the requirements that must be met prior to performing a procedure, treatment or intervention.

In addition, this publication also discusses delegation, fetal ultrasound for non-medical purposes and issues affecting students and applicants prior to their registration with CMRTO.

Once published, "What you must know about ... performing procedures for medical radiation and imaging technologists" will be shared with all members via email and saved on the website for easy reference. Please be on the lookout for this important resource later this fall.

Information sessions

Join Registrar & CEO Linda Gough for information sessions across the province this fall. Topics will include: orders for imaging and therapeutic procedures, the regulation of diagnostic medical sonographers, new electoral districts and expected changes to CMRTO's name and visual identity.

Linda will be visiting the following locations:

Ajax
Monday, October 29, 2018
7:00 pm - 9:00 pm
Ajax Convention Centre
550 Beck Crescent
Room: Westney Ballroom, Main Level

Ottawa
Tuesday, October 30, 2018
7:00 pm - 9:00 pm
Ottawa Conference and Event Centre
200 Coventry Rd
Room: Lecture Room 110, Main Floor

Thunder Bay
Thursday, November 1, 2018
7:00 pm - 9:00 pm
Valhalla Inn
1 Valhalla Inn Road
Room: Ballroom

Toronto
Monday, November 5, 2018
7:00 pm - 9:00 pm
The Michener Institute for Applied Health Sciences
222 St. Patrick Street
Room: Auditorium, Ground Floor

Hamilton
Tuesday, November 6, 2018
7:00 pm - 9:00 pm
Carmen's Banquet Centre
1520 Stone Church Road East
Room: Venetian Ballroom

Sudbury
Monday, November 12, 2018
7:00 pm - 9:00 pm
Holiday Inn Sudbury
1696 Regent Street
Room: Georgian Room D

Brampton
Tuesday, November 13, 2018
7:00 pm - 9:00 pm
Courtyard Marriott Toronto Brampton
90 Biscayne Crescent
Room: Windsor B

London
Wednesday, November 14, 2018
7:00 pm - 9:00 pm
Four Points by Sheraton London
1150 Wellington Road South
Room: Balmoral A, Mezzanine Floor, Main Entrance

Take advantage of this opportunity to learn more about your CMRTO, network with other members and ask your most pressing questions about the regulation of medical radiation and imaging technologists in Ontario.

And enjoy a coffee and cookie while earning two hours of continuing education for your QA program.

For more information, please visit For more information about these sessions, please click here.

Update on the registration of diagnostic medical sonographers

For the past ten months, CMRTO staff have been helping diagnostic medical sonographers apply to and register as members of CMRTO.

We are pleased to report that, as of October 15th, a total of 2,705 diagnostic medical sonographers have either been approved for registration or have already registered with the CMRTO! This is a considerable accomplishment representing over 71% of the applications received at this point.

The following chart outlines the status of the applications received to date (October 15, 2018).

Submitted applications ready to be reviewed	457
Submitted applications under review by staff	616
Total applications	**1,073**
Approved applications - eligible for registration	1,848
Registered in DMS - new members	642
Registered in DMS - active in another specialty(ies)	157
Registered in DMS - past member in another specialty(ies)	58
Total registered or approved	**2,705**

Apply Now!

The application review and approval process may take up to four months for CMRTO to complete, as evaluating each applicant's skills, experience and education to determine if they meet the registration requirements outlined in the regulation made under the *Medical Radiation Technology Act* (MRT Act) is a complex and time-intensive process. Once your application has been reviewed, you will be notified about the status of your application. If any additional information is required, you will be notified as soon as possible.

In less than three months' time, anyone wishing to practise diagnostic medical sonography must be registered with the CMRTO to do so legally in the province of Ontario. Anyone practising diagnostic medical sonography without being registered with the CMRTO could be subject to a fine, professional sanctions and/or provincial offence charges.

As well, changes to the Controlled Acts regulation made under the *Regulated Health Professions Act* come into force on the same date. Effective January 1, 2019, only members of the CMRTO, College of Physicians and Surgeons of Ontario, College of Nurses of Ontario and College of Midwives of Ontario will be authorized to perform the controlled act of applying soundwaves for diagnostic ultrasound examinations. As a result, if you or anyone you know is currently practising or hopes to practise diagnostic medical sonography in Ontario after **January 1, 2019**, it is critical to apply for registration immediately to avoid delay or prosecution.

We cannot guarantee that we can process applications submitted after **November 16, 2018** in time for sonographers to become registered by **December 31, 2018.** Also, we suggest that those applicants who have already received confirmation that their application has been approved complete the registration process by **December 15, 2018**. We want to ensure that all DMSs are registered and ready to work by December 31, 2018.

To start your application now, or to complete your already-started application, please click here. For more details on the application process and requirements for registration, please review our application guide by clicking here.

Important dates

Important Dates
Apply by November 16, 2018
Register by December 15, 2018

New Quality Assurance Manager and Professional Practice Advisor

In August, two CMRTO members joined our staff as Quality Assurance Manager and Professional Practice Advisor.

Janet Maggio, Quality Assurance Manager, is an MRT in the specialties of nuclear medicine and magnetic resonance. Janet holds a Bachelor of Science from the University of Guelph, and recently obtained a Master of Science in Health Science Education from McMaster University. Her master's thesis was on Quality Assurance and its critical importance in maintaining competency in a profession. Most recently, Janet was the Director of Professional Services at the Ontario Association of Medical Radiation Sciences. Before that, she was a professor at the Michener Institute for Allied Health Sciences for ten years where she taught nuclear medicine technology. Janet also has 13 years of experience in providing clinical services to patients in both nuclear medicine and magnetic resonance in a full-time and casual capacity.

Tina White, Professional Practice Advisor, is an MRT in the specialties of magnetic resonance and radiography. Tina completed a program in radiography at the Eastern Ontario School of X-Ray Technology in Kingston and obtained her post-graduate fellowship in CT/MRI Technology from the University of Virginia. She has 24 years of experience in radiography, CT and MRI including 18 years as an MRI Charge Technologist and MRI Safety Officer at the Scarborough & Rouge Hospital. Tina also has more than 15 years of clinical experience, including

teaching, research and policy, at a number of different facilities including tertiary care hospitals and clinics, both in Ontario and Charlottesville, Virginia.

Tina is able to speak conversational French and Janet is bilingual. They started their new positions on Monday, August 20, 2018.

CMRTO is excited to have such well qualified MRTs join our team, and hope that you join us in welcoming Janet and Tina!

Janet Maggio

Tina White

Webinars

This fall, CMRTO is hosting a webinar series covering a wide range of topics related to the practice of medical radiation and imaging technology in Ontario. These 45-minute webinars are designed to be short, practical and informative sessions for new and established members alike.

Here is the fall webinar series schedule:

What Happens January 1, 2019?
Thursday, September 27, 2018
1:00 pm

Effective January 1, 2019, the regulation of diagnostic medical sonography will be fully implemented in Ontario. All sonographers must be registered with CMRTO in order to be legally authorized to practise the profession and to apply soundwaves for diagnostic ultrasound procedures. This webinar will help you understand how the regulation of sonographers by CMRTO affects you and will outline any steps you need to take to ensure that you're ready and able to practice in the new year.

Click here to view a recording of this webinar.

Myths, Rumours & Urban Legends
Thursday, October 4, 2018
1:00 pm

Join Registrar & CEO Linda Gough as she discusses some of the myths, rumours and urban legends about the regulation of medical radiation and imaging technology and answers some of our most commonly asked questions.

Click here to view a recording of this webinar.

Professional Accountability and Getting to Know Your College
Thursday, October 11, 2018
1:00 pm

What is regulation? What is CMRTO's role in regulating medical radiation and imaging technologists? Participants in this session will learn about the structure of CMRTO, including Registration, Quality Assurance and Complaints. Learn more about us and your professional obligations in this informative webinar.

Click here to view a recording of this webinar.

CMRTO QA Program – Simplified!
Thursday, October 25, 2018
1:00 pm

In this session, Director of Quality Assurance Annette Hornby will lead participants through a review of the objectives, components and timelines of CMRTO's Quality Assurance program. In addition to helping you understand how the QA program works and what's required of members each year, this webinar will provide helpful hints and tips to help you fulfil your annual QA requirements.

Register now for CMRTO QA Program – Simplified!

What you must know about ... performing procedures for medical radiation and imaging technologists
Thursday, November 15, 2018
1:00 pm

The CMRTO's Standards of Practice require members to ensure that an appropriate order – an authorizing statement from a regulated health professional with prescribing authority – is in place prior to performing a procedure, treatment or intervention. Join Registrar & CEO Linda Gough as she explains the different types of orders, who can issue an order, the practice of delegation and the various steps involved in determining when to implement a procedure as ordered in this practical and informative webinar.

Register now for What you must know about ... performing procedures for medical radiation and imaging technologists

What you must know about ... mandatory reporting and complaints
Thursday, November 22, 2018
1:00 pm

What is mandatory reporting? When are you responsible for reporting professional misconduct, sexual abuse, professional negligence, incompetence or incapacity to the College? In this session, Director of Professional Conduct Tina Langlois discusses mandatory reporting as it pertains to medical radiation and imaging technologists, outlines key roles and responsibilities of members and departments and provides an overview of the complaints process.

Register now for What you must know about ... mandatory reporting and complaints

To register for any of these upcoming webinars, please click on the links above or visit the CMRTO website for additional information.

Suspended Members

The following members' certificates of registration were suspended between July 31, 2018 and October 5, 2018 for failure to pay their fees in accordance with section 24 of the Health Professions Procedural Code.

A person whose certificate of registration has been suspended is not a member of the CMRTO unless and until the suspension is removed.

15999	Melissa Paquet

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The mission of the CMRTO is to regulate the profession of medical radiation technology to serve and protect the public interest.

VISION: The CMRTO is a future-focused, responsive, collaborative regulator committed to excellence.

VALUES: Integrity | Fairness | Transparency | Respect | Professionalism

Registrar & CEO Linda Gough

President Wendy Rabbie

Vice President Jay A. Neadles

inSIGHTS is published by the College of Medical Radiation Technologists of Ontario and is distributed to all members.

Editor Linda Gough

Design and Production
c(group

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Social Reach Consulting

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Kirusha Kobindarajah

From: CMRTO Quality Assurance <communications@cmrto.org>
Sent: November-1-18 8:11 AM
To: Jef Ekins <jef.ekins@cmrto.org>
Subject: CMRTO QA Reminder

The QA year is almost over!

As part of your professional obligations, all CMRTO members are required to complete the QA ePortfolio and at least 25 hours of continuing education and professional development activities each year.

As there are only two months left in the QA year, you should now be almost finished your QA ePortfolio – your QA Profile and Self-Assessment should be complete, and most (if not all) of your 25 hours of continuing education and professional development activities should now be completed and recorded in your ePortfolio.

The CMRTO monitors members' participation in the QA program through the ePortfolio tool which provides de-identified statistical data about members' participation in the ePortfolio.

On October 31, 2018, 49% of members still had not started their 2018 QA ePortfolio and only 14% had completed their QA requirement.

October 31, 2018 QA Update		
	Number	**%**
Active Members	**8,121**	
Members who have completed their 2018 ePortfolio	**1,124**	**14%**
Members who have started their 2018 ePortfolio	**2,974**	**37%**
Members who have not started their 2018 ePortfolio	**4,023**	**49%**

If you are among the 14% who have completed your 2018 QA ePortfolio, thank you – please enjoy the rest of the year worry-free. If you have still not started your ePortfolio, have not completed your continuing education and professional development activities, or have yet to finalize and submit your ePortfolio, it's time to stop procrastinating and get to work. You only have two months left!

You can access your 2018 ePortfolio through the Member & Applicant Portal (MAP) of the CMRTO website. Click here to login to MAP and start today!

New to the QA process or need a refresher to help get you started? Read our 'Tips for completing your QA portfolio'.

You can also click here to watch a recording of our recent webinar "CMRTO QA Program – Simplified!" which answers many of your questions about the QA program.

CMRTO QuickQA App

Want a faster, easier way to record your activities? Download the CMRTO QuickQA App to a smartphone or tablet to help record your continuing education and professional development activities in the ePortfolio in real time. Click here for more information on how to download the app to your device. Call Janet or Cathy at 416.975.4353 or 1.800.563.5847 or email qa@cmrto.org for your QuickQA password.

Thank you,

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Have any questions about this email? Contact communications@cmrto.org

Kirusha Kobindarajah

From: CMRTO Communications <communications@cmrto.org>
Sent: November-14-18 11:04 AM
To: Jef Ekins <jef.ekins@cmrto.org>
Subject: What you must know about ... performing procedures ... and mandatory reporting

Dear contact.firstname,

Please find attached two new publications – *What you must know about ... performing procedures for medical radiation and imaging technologists* and *What you must know about ... mandatory reporting* – that CMRTO members must know, understand and apply in their practice.

What you must know about ... performing procedures for medical radiation and imaging technologists includes information about:

- performing procedures within the scope of practice of the profession
- having the knowledge, skills and judgement to perform a procedure
- ensuring that the appropriate order authorizing the performance of a procedure, treatment or intervention is place prior to performing that procedure, treatment or intervention
- performing procedures in accordance with the Standards of Practice
- fetal ultrasound for non-medical purposes
- issues affecting students and applicants prior to their registration with CMRTO

In addition to this comprehensive collection of information, *WYMKA ... performing procedures* also includes a decision-making guide for performing a procedure, a practical and useful tool that all medical radiation and imaging technologists will find helpful in carrying out their responsibilities.

What you must know about ... mandatory reporting is an updated version of an earlier publication of the same name. This publication outlines the obligation under the *Regulated Health Professions Act, 1991* and the Health Professions Procedural Code for members of the CMRTO, employers and facility operators to file written reports to the College.

Mandatory reporting is the best means of ensuring that instances of professional misconduct, incompetence, professional negligence, sexual abuse or concerns regarding incapacity are brought to the attention of the CMRTO. Once identified, CMRTO is then responsible for investigating these reports to protect the public from harm.

This publication outlines the responsibility of members to report actions and behaviours to the CMRTO regarding medical radiation and imaging technologists.

In addition to the links to these files above, these publications are also available on the CMRTO website.

Please review these two documents thoroughly to ensure that you understand and are able to apply the information to your daily responsibilities as a medical radiation and imaging technologist.

As well, please note that CMRTO will be hosting free webinars about these publications on Thursday, November 15th and Thursday, November 22nd.

Please click here to register for *What you must know about ... performing procedures for medical radiation and imaging technologists* on **November 15th at 1 pm.**

Please click here to register for *What you must know about ... mandatory reporting* on **November 22nd at 1 pm.**

If you have any questions about these publications, or require additional information, please contact CMRTO at communications@cmrto.org.

Thank you,

Linda Gough, MRT(R) Registrar & CEO

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College of
Medical Radiation
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Ontario

Ordre des
technologues en
radiation médicale
de l'Ontario

What you must know about...

performing procedures for medical radiation and imaging technologists

November 2018

CMRTO
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Introduction

As regulated health professionals, members of the College of Medical Radiation Technologists of Ontario (CMRTO) are accountable to their patients and the public to provide safe, effective and ethical medical radiation and imaging technology services. Members of the CMRTO do this every day by ensuring that their practice meets the legislative requirements and standards of the profession.

In this publication, "members" refers to all members of the CMRTO; that is, members in all of the five specialties: radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography. In this publication, "profession" refers to the profession of medical radiation and imaging technology.

Members of the CMRTO are qualified medical radiation and imaging professionals who use ionizing radiation, electromagnetism, and soundwaves to produce diagnostic images of a patient's body or who administer radiation to treat patients for certain medical conditions, on the order of a physician or other authorized health professional.

Members of the CMRTO must perform medical radiation and imaging procedures in accordance with the Standards of Practice of the profession. The Standards of Practice describe what each member is accountable and responsible for in practice. The Standards of Practice reflect the knowledge, skills and judgement that members need in order to perform the services and procedures that fall within the scope of practice of the profession.

The purpose of this publication is to outline the information that members must understand regarding the performance of medical radiation and imaging technology procedures in accordance with the Standards of Practice, including:

1. performing procedures within the scope of practice of the profession,

2. having the knowledge, skills and judgement to perform a procedure, and

3. ensuring that the appropriate order authorizing the performance of a procedure, treatment or intervention is in place prior to performing that procedure, treatment or intervention.

These requirements are discussed in detail in Part I below. Part I also includes a summary of the conditions that must be met prior to performing a procedure, treatment or intervention.

Part II of this publication touches on related topics such as delegation, fetal ultrasound for non-medical purposes and issues affecting students and applicants prior to their registration with CMRTO.

Part I

Requirement 1: Scope of practice

Members must perform procedures, including authorized acts, only in the course of engaging in the practice of medical radiation and imaging technology.

The scope of practice statement for the profession under the *Medical Radiation Technology Act* is as follows:

"The practice of medical radiation [and imaging] technology is the use of ionizing radiation, electromagnetism [soundwaves] and other prescribed forms of energy for the purposes of diagnostic or therapeutic procedures, the evaluation of images and data relating to the procedures and the assessment of an individual before, during and after the procedures."[1]

Requirement 2: Knowledge, skills and judgement

The Standards of Practice of the profession state that members must have and maintain the knowledge, skills and judgement to safely perform procedures undertaken in the course of the practice of the profession.

Members are required to have the knowledge, skills and judgement necessary to perform the procedure, treatment or intervention. If they do not, they **must** refrain from performing the procedure, treatment or intervention – even if a valid order is in place.

[1]The text in square brackets provides the changes that will come into effect when the *Medical Radiation and Imaging Technology Act* comes into force.

What should a member do if they are not competent to perform a procedure?

Members must maintain competence in their current area(s) of practice, must refrain from acting if not competent and must take appropriate action to address the situation. The appropriate action when not competent to perform a procedure will vary depending on the situation.

For example: if performing the procedure is part of a member's regular role expectations within a particular practice setting, then the member should obtain the competencies necessary to provide safe, effective and ethical services to those patients in their care. The member may also consult with their supervisor or manager to determine how this may be achieved. On the other hand, if performing the procedure is not part of a member's regular role expectations, the appropriateness of obtaining the competencies should be evaluated.

In making this decision, the member is ultimately responsible to ensure that they are competent to provide the medical radiation or imaging services required by patients within a particular practice setting.

Requirement 3: Orders

The CMRTO's Standards of Practice require members to ensure that the appropriate order authorizing the performance of a procedure, treatment or intervention is in place.[2] This applies to all procedures performed by all members in all of the five specialties: radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography.

What is an order?

An order is an authorizing statement from a regulated health professional with prescribing authority, permitting members to perform a procedure, treatment or intervention that falls within a member's scope of practice. An order may also be called a requisition or treatment plan.

Members must ensure that the appropriate order is in place ***prior*** to performing a procedure, treatment or intervention.

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[2] This standard of practice is set out in indicator (d) of Standard 3: Diagnostic and Therapeutic Procedures. The Standards of Practice are sent to all CMRTO members by email and are available on the CMRTO website at www.cmrto.org.

Who can issue an order?

The regulated health professional with ordering authority will vary depending on the procedure, treatment or intervention.

The source of the ordering authority will also vary, as set out in the table below:

Type of procedure, treatment or intervention	Required order(s)
Application of ionizing radiation	The order must be from a physician or other authorized health professional listed in the *Healing Arts Radiation Protection Act* or regulations[3,4]
Nuclear medicine procedures	The order must be from a person authorized under the regulations made under the *Public Hospitals Act* or in accordance with generally accepted professional standards established under the *Independent Health Facilities Act*
Application of electromagnetism for magnetic resonance imaging procedures	The order must be from a physician or another authorized health professional listed in the Controlled Acts regulation made under the *Regulated Health Professions Act*[5]
Application of soundwaves for diagnostic medical sonography	The order must be from a physician or another authorized health professional listed in the Controlled Acts regulation made under the *Regulated Health Professions Act*[6]

[3]On a date to be named by proclamation of the Lieutenant Governor, the *Healing Arts Radiation Protection Act*, RSO 1990, c H 2 will be repealed and replaced with the *Oversight of Health Facilities and Devices Act, 2017*. If and when the Act is proclaimed, it will expand the current scope of regulated devices beyond only x-ray machines to all existing and emerging energy applying and detecting medical devices (EADMDs). Until such a time as the Act is proclaimed, the HARP Act continues in force.

[4]See Appendix A.

[5]See Appendix B.

[6]See Appendix C.

Performance of authorized acts[7], which are:
• administering substances by injection or inhalation;
• tracheal suctioning of a tracheostomy;
• administering contrast media or putting an instrument, hand or finger,
  • beyond the opening of the urethra,
  • beyond the labia majora,
  • beyond the anal verge, or
  • into an artificial opening of the body; and
• performing a procedure on tissue below the dermis.
	The order must be from a physician.

What types of orders exist?

An order may be one of two types: (1) direct order or (2) medical directive or protocol.

1. Direct orders

An order may be a direct order for a specific procedure, treatment or intervention, for a specific patient, by a physician or other authorized health professional.

Under the regulations made under the *Public Hospitals Act* (PHA), every order must be:

- in writing[8]
- dated
- authenticated by the ordering physician or other authorized health professional

The order should also include the details required to perform the procedure, treatment or intervention. For example:

- patient name and date of birth
- date and time the order was made
- name of the procedure or substance being ordered, and, when a substance is being ordered, the details required to administer the substance[9]

[7]Other than the application of electromagnetism for magnetic resonance imaging procedures and the application of soundwaves for diagnostic medical sonography.

[8]Although directed orders are generally in writing, provision has been made pursuant to regulations made under the *Public Hospitals Act* for telephone and electronically transmitted orders. Verbal prescriptions, on the other hand, are made pursuant to the provisions of the *Drug and Pharmacies Regulation Act*.

[9]The details required to administer the substance may include the dosage, the route of administration, and the frequency with which the substance is to be administered.

In order to deal properly with telephone orders or requests, health professionals who work in hospitals governed by the PHA are expected to:

- ensure they have been designated by the hospital administrator as someone who can accept telephone orders
- transcribe the order along with the name of the physician or other authorized health professional who dictated the order, along with the date and time it was received
- sign the order
- ensure that if someone else has transcribed the telephone order, that the person has the authority to accept such orders before procedure, treatment or intervention is performed[10]

Members are also encouraged to review their organization's policies about telephone orders or requests.

2. Medical directive or protocol

An order may also be made through a medical directive or protocol (also known as a standing order). A medical directive is an order for a procedure, treatment or intervention for a range of patients who meet specific conditions, authorized by a physician, and implemented by another individual, such as a nurse, physiotherapist, physician assistant or member of the CMRTO.

Medical directives are always written or documented electronically. They cannot be verbal.

Medical directives or protocols must contain:

- a standardized reference number
- identification of the specific procedure, treatment or range of treatments being ordered
- identification of who specifically may implement the procedure under the authority of and according to the medical directive (may be an individual or a group)
- specific patient conditions that must be met before the procedure(s) can be implemented
- any circumstances that must be met before the procedure(s) can be implemented
- any contraindications for implementing the procedure(s)

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[10] These responsibilities are set out in the Hospital Management Regulation made under PHA at s. 24(3). The Regulation also provides that the physician or other authorized health professional who dictated the order shall authenticate the order on the first visit to the hospital after dictating the order.

- documentation requirements
- quality monitoring mechanisms
- the name and signature of the physician, or other authorized health professional, authorizing the medical directive
- the date and signature of the administrative authority approving the medical directive

When are medical directives or protocols used?

Generally, medical directives or protocols may be used as the authority for performing procedures when a health professional has the knowledge, skills and judgement to determine that the conditions and circumstances described in the medical directive have been met. Procedures that require the direct assessment of a patient by a physician require direct orders and are not appropriate for implementation under a medical directive or protocol.

For example: an order to perform a CT scan on a particular patient would be a direct order from the patient's physician; whereas the injection of the contrast media necessary to complete the CT scan may be covered under a medical directive or protocol from the department's radiologist.

What should a member do if they have concerns about an order or treatment plan?

If a member has a concern about the accuracy or appropriateness of an order or treatment plan, they should take appropriate action to address the situation. Although the appropriate steps may vary depending on the situation, resolving the concerns will involve:

1. discussing the concern directly with the health professional responsible for the order or treatment plan
2. identifying the outcomes desired for resolution
3. providing a rationale and best practice evidence in support of the concern
4. documenting the concern and the steps taken to resolve the concern in the appropriate record

What conditions must be met prior to performing a procedure, treatment or intervention?

The conditions which must be met before performing procedures or treatments are set out in the CMRTO Standards of Practice. In accordance with Practice Standard 3: Diagnostic and Therapeutic Procedures, members must:

1. ensure that the appropriate order authorizing the procedure is in place
2. perform procedures, including authorized acts, only in the course of engaging in the practice of medical radiation and imaging technology
3. not perform procedures contrary to any terms, conditions or limitations placed upon the member's certificate of registration[11]
4. have and apply the necessary knowledge, skill and judgement to perform and manage the outcomes of performing the procedure safely, effectively and ethically
5. ensure that patient consent has been obtained[12]
6. be responsible and accountable for performing the procedure and managing the outcomes, having considered:
   a. the known risks to the patient in performing the procedure
   b. the predictability of the outcomes in performing the procedure
   c. whether the management of the possible outcomes is within the member's knowledge, skill and judgement, given the situation
   d. any other factors specific to the situation to ensure the procedure is implemented safely, effective and ethically
7. not perform any procedure or provide any advice which may result in serious bodily harm unless that procedure or advice is within the scope of practice of the profession or the member is authorized or permitted to do so by legislation

At the end of this publication, members will find a decision-making guide to assist them in determining whether or not they should implement a procedure.[13]

[11] As of January 1, 2018, a condition was added to each member's certificate of registration, as follows: "The member shall practise only in the areas of medical radiation and imaging technology in which the member is educated and experienced." This addition was made to accommodate the different areas within each specialty in which members are practising, and to provide for the three areas of practice of DMS – general, cardiac and vascular.

[12] It is important to note that consent may be withdrawn at any time. If a patient withdraws their consent, a member must discontinue the treatment or procedure, notwithstanding the existence of an order. For more information, please consult the CMRTO publication *What you must know about ... Health Care Consent Act*. This publication contains consent guidelines for members of CMRTO.

[13] See Appendix D.

Part II

Delegation

As discussed in Part I above, the CMRTO's Standards of Practice require members to ensure that the appropriate order authorizing the performance of a procedure, treatment or intervention is in place prior to performing that procedure, treatment or intervention. However, there are instances where a member may be asked to accept and perform procedures beyond the principal expectations of practice. This occurs through the process of delegation, which involves a controlled act that is not authorized to members.

What are controlled acts?

Under the *Regulated Health Professions Act, 1991* (RHPA), regulated health professionals may be authorized to perform one or more of 14 controlled acts. Under the *Medical Radiation Technology Act, 1991* (MRT Act), members of CMRTO are authorized to perform five of the 14 controlled acts set out in the RHPA (the authorized acts).

All 14 controlled acts are set out in the table below. For reference, the five controlled acts that members of the CMRTO are authorized to perform appear in bold (see controlled acts 2, 5, 6, and 7).

Controlled Act	Description
1	Communicating to the an individual or their personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or their personal representative will rely on the diagnosis.
2	**Performing a procedure on tissue below the dermis**, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3	Setting or casting a fracture of a bone or a dislocation of a joint.
4	Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5	**Administering a substance by injection or inhalation.**

6	**Putting an instrument, hand or finger,** i. beyond the external ear canal, ii. beyond the point in the nasal passages where they normally narrow, **iii. beyond the larynx,**[14] **iv. beyond the opening of the urethra,** **v. beyond the labia majora,** **vi. beyond the anal verge, or** **vii. into an artificial opening into the body.**
7	**Applying** or ordering the application of **a form of energy prescribed by the regulations under the RHPA.**[15]
8	Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9	Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10	Prescribing a hearing aid for a hearing impaired person.
11	Fitting or dispensing dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12	Managing labour or conducting the delivery of a baby
13	Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

Controlled acts may only be performed by health professionals in their practice if:

- the controlled act is authorized to them under the profession-specific legislation; or
- the controlled act is delegated to them by a health professional who is authorized to perform it; or
- an exception or exemption exists.

[14]Under the MRT Act, members of the CMRTO are authorized to perform a "tracheal suctioning of a tracheostomy."

[15]The forms of energy prescribed by the regulations under the RHPA include electricity, soundwaves for diagnostic ultrasound and electromagnetism for magnetic resonance imaging.

What is delegation?

Under the RHPA, delegation is the process by which a regulated health professional authorized to perform a controlled act confers that authority to someone – regulated or unregulated – who is not authorized. Delegation may be conferred and established by order or by designation.

Members of CMRTO do not typically perform delegated acts, as most of the controlled acts they perform in their practice fall under the five authorized acts they have the authority to perform. However, on occasion, some members will accept delegation of a controlled act which is not one of the five authorized acts.

For example: communicating to an individual or their personal representative a diagnosis is not one of the controlled acts authorized to members of CMRTO. However, members in the specialty of nuclear medicine may need to communicate the results of a pregnancy test to their patient after performing a pregnancy test. This is because pregnancy may be a contraindication for certain nuclear medicine procedures, due to the high risk to the fetus.

How do I determine if it's appropriate to accept a delegation and perform a procedure?

Under the CMRTO Standards of Practice, members may accept the delegation of controlled acts under the RHPA that are not authorized under the MRT Act, provided that members comply with the RHPA and the CMRTO Standards of Practice. Members may perform controlled acts on the basis of delegation only when the following conditions have been met:

- the health professional who is delegating the controlled act (the delegator) is a member of a regulated health profession authorized by their health profession Act to perform the controlled act;
- the delegator is acting in accordance with any applicable legislation and any guidelines and policies of their regulatory body governing delegation, and has not been restricted or prohibited from delegating the controlled act;
- the delegator has the knowledge, skills and judgement to perform and delegate the controlled act;
- the member has the knowledge, skills and judgement to perform the controlled act delegated to them safely, effectively and ethically given the circumstances of the situation;

- a written record of the transfer of authority (delegation) and certification of the CMRTO member's competence is maintained; and
- the member complies with any conditions established by the delegator in order for the member to maintain the authority of the controlled act.

It is important for members to understand, however, that under the CMRTO Standards of Practice, CMRTO members **cannot** delegate their authorized acts to other individuals.

Fetal ultrasound for non-medical reasons

Physicians and other authorized health professionals routinely order diagnostic ultrasounds of the fetus during their patient's pregnancy. While diagnostic ultrasound is an essential component of prenatal care, ultrasound technology is used by others for non-medical reasons, such as for fetal portraits, keepsake videos, heartbeat recordings or gender identification.

CMRTO members must only perform procedures, including the authorized acts, in the course of engaging in the practice of the profession (the scope of practice for DMSs is the use of soundwaves for the purposes of diagnostic or therapeutic procedures, the evaluation of images or data relating to the procedure, and the assessment of an individual before, during and after the procedure). The Controlled Acts regulation made under the RHPA requires members to only apply soundwaves for diagnostic ultrasound procedures when they have an order from a physician or other authorized health professional. Therefore, it would be professional misconduct for a CMRTO member to use ultrasound only to obtain a picture or video of a fetus or to determine gender for non-medical reasons.

Students and applicants

There are exemptions in place under the RHPA and the HARP Act that permit students to perform authorized acts and apply ionizing radiation while they are students actively enrolled in an approved educational program, provided they are supervised by a member of CMRTO.

In order to practise as a medical radiation technologist in Ontario, an individual must be registered with the CMRTO. Effective January 1, 2019, an individual must be registered with CMRTO in order to practise as a diagnostic medical sonographer.[16]

Prior to receiving a certificate of registration, all applicants are required to successfully complete an approved program, successfully complete an approved examination and meet other requirements as defined by the registration regulation.

In between completing an educational program and becoming registered with CMRTO, an individual is **not**:

- authorized to apply ionizing radiation to human beings in Ontario, or
- authorized to perform any of the controlled acts authorized to CMRTO members, including:
  - the application of electromagnetism for magnetic resonance imaging procedures, and
  - the application of soundwaves for diagnostic medical sonography.

The same is true even if the individual is doing so under the supervision of a member of the CMRTO.

Remember ... CMRTO staff are available by phone or email to assist members in understanding their professional obligations and their accountabilities. If you have any further questions regarding performing procedures or practise advice as a medical radiation or imaging technologist, please contact the CMRTO Practice Advisor.

[16] This includes all areas of practice of diagnostic medical sonography: general, cardiac and vascular.

Appendix A: Ordering and applying ionizing radiation

The *Healing Arts Radiation Protection Act* (HARP Act) provides that no person shall operate an x-ray machine for the irradiation of a human being unless the irradiation has been prescribed as follows:

Health care professional	Ordering authority	Authority to apply
A legally qualified medical practitioner	A legally qualified medical practitioner, or member of the College of Physicians and Surgeons of Ontario, can order the application of ionizing radiation without restriction, provided that they do so in accordance with the expectations set out in the practice standards of CPSO.	Yes
Member of the Royal College of Dental Surgeons of Ontario	When ordering the application of ionizing radiation for dental radiographs and dental CTs, a dentist is accountable to the expectations set out in the practice standards of their College.	Yes
Member of the College of Chiropodists of Ontario	Member must have been continuously registered as a chiropodist under the *Chiropody Act* and the *Chiropody Act, 1991* since before November 1, 1980 or who is a graduate of a four-year course of instruction in chiropody (a Doctor of Podiatric Medicine (DPM) degree).	Yes
Member of the College of Chiropractors of Ontario	When ordering the application of ionizing radiation, a member must adhere to the Standards of Practice of the College of Chiropractors of Ontario.	Yes
Member of the College of Nurses of Ontario	To order the application of ionizing radiation, a member must hold an extended certificate of registration under the *Nursing Act, 1991* (Nurse Practitioner or NP). Previously, NPs could only order x-rays based on lists under the RHPA and the HARP Act. Changes in 2018 eliminated these lists. Now, NPs can order all x-rays (except CTs). When ordering the application of ionizing radiation, NPs are accountable to the expectations set out in the practice standards of their College.	No

Member of the College of Physiotherapists of Ontario	To order the application of ionizing radiation, the irradiation must be prescribed in a manner permitted by the regulations. As of the date of publication, no regulation has been made.	No
Member of the College of Dental Hygienists of Ontario	Members have no ordering authority under HARP.	Yes
Member of the College of Medical Radiation Technologists of Ontario	Members have no ordering authority under HARP. Members do not need an order with respect to the application of ionizing radiation for mammography procedures under the Ontario Breast Screening Program in accordance with s. 6 of R.R.O. 1990, Reg. 543 made under the HARP Act.	Yes

For more information regarding ordering and applying ionizing radiation, please contact CMRTO or the College of the relevant health care professional listed in the HARP Act.

Appendix B: Ordering and applying electromagnetism for magnetic resonance imaging

The Controlled Acts Regulation made under the *Regulated Health Professions Act, 1991* sets out those who can apply and order the application of electromagnetism for magnetic resonance imaging.

Health care professional	Ordering authority	Authority to apply electromagnetism
Member of the College of Physicians and Surgeons of Ontario	A member of the CPSO can order the application of electromagnetism provided that the conditions set out in the Regulation are met.[1]	Yes, provided that the conditions set out in the Regulation are met.[2]
Member of the College of Medical Radiation Technologists of Ontario	A member of the CMRTO cannot order the application of electromagnetism for magnetic resonance imaging.	Yes, but only with an order from a member of the CPSO and only if the conditions set out in the Regulation are met.[3]

For more information regarding ordering and applying electromagnetism for magnetic resonance imaging, please consult O. Reg. 107/96 or contact the CMRTO.

[3]Section 5(2) of O. Reg. 107/96 provides that a member of the CPSO is exempt from subsection 27(1) of the Act for the purpose of applying or ordering the application of electromagnetism if:

(a) the electromagnetism is applied for magnetic resonance imaging using equipment that is,
  (i) installed in a site of a public hospital where the public hospital is approved as a public hospital under the *Public Hospitals Act* and the site of the public hospital is graded under that Act as a Group N site of a hospital, and
  (ii) operated by the public hospital mentioned in subclause (i);

(a.1) the electromagnetism is applied for magnetic resonance imaging using equipment that is installed in, and operated by, the University of Ottawa Heart Institute;

(b) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:
  (i) the electromagnetism is used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*;
  (ii) the magnetic resonance imaging is provided to persons who are insured persons within the meaning of the *Health Insurance Act*,
  (iii) the electromagnetism is applied in an independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging; or

(c) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:
  (i) the electromagnetism is not used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*, or the magnetic resonance imaging is not provided to persons who are insured persons within the meaning of the Act, or both,
  (ii) the electromagnetism is applied in a facility that is operated by an operator that holds a licence under the *Independent Health Facilities Act* in respect of magnetic resonance imaging,
  (iii) the electromagnetism is applied in a facility that is operated on the same premises as the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),
  (iv) the electromagnetism is applied using the same equipment that is used to provide magnetic resonance imaging in the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),
  (v) the operator of the facility in which the electromagnetism is applied is a party to a valid and subsisting agreement with the Minister concerning the provision of magnetic resonance imaging.

[4]Please see footnote 1 above.

[5]Section 3.1 of O. Reg. 107/96 provides that a member of the CMRTO is exempt from subsection 27(1) of the Act for the purpose of applying electromagnetism if the application is ordered by a member of the CPSO and:

(a) the electromagnetism is applied for magnetic resonance imaging using equipment that is,
  (i) installed in a site of a public hospital where the public hospital is approved as a public hospital under the *Public Hospitals Act* and the site of the public hospital is graded under that Act as a Group N site of a hospital, and
  (ii) operated by the public hospital mentioned in subclause (i);

(a.1) the electromagnetism is applied for magnetic resonance imaging using equipment that is installed in, and operated by, the University of Ottawa Heart Institute;

(b) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:
  (i) the electromagnetism is used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*;
  (ii) the magnetic resonance imaging is provided to persons who are insured persons within the meaning of the *Health Insurance Act*,
  (iii) the electromagnetism is applied in an independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging; or

(c) the electromagnetism is applied for magnetic resonance imaging and all of the following conditions are met:
  (i) the electromagnetism is not used to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act*, or the magnetic resonance imaging is not provided to persons who are insured persons within the meaning of that Act, or both,
  (ii) the electromagnetism is applied in a facility that is operated by an operator that holds a licence under the Independent *Health Facilities Act* in respect of magnetic resonance imaging,
  (iii) the electromagnetism is applied in a facility that is operated on the same premises as the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),
  (iv) the electromagnetism is applied using the same equipment that is used to provide magnetic resonance imaging in the independent health facility licensed under the *Independent Health Facilities Act* in respect of magnetic resonance imaging that is operated by the operator mentioned in subclause (ii),
  (v) the operator of the facility in which the electromagnetism is applied is a party to a valid and subsisting agreement with the Minister concerning the provision of magnetic resonance imaging.

Appendix C: Ordering and applying soundwaves for diagnostic ultrasound

The Controlled Acts Regulation made under the *Regulated Health Professions Act, 1991* sets out those who can apply and order the application of soundwaves for diagnostic ultrasound.

For the purposes of the Regulation, "diagnostic ultrasound" means ultrasound that produces an image or other data.

This chart sets out which health professionals have the authority to order and/or apply soundwaves for diagnostic ultrasound, effective January 1, 2019.

Health care professional	Ordering authority	Authority to apply soundwaves
Member of the College of Physicians and Surgeons of Ontario	A member of the CPSO can order the application of soundwaves for diagnostic ultrasound.	Yes
Member of the College of Midwives of Ontario	A member of the CMO can order the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound.	Yes, but only pregnancy or pelvic diagnostic ultrasound.
Member of the College of Nurses of Ontario (Registered Nurse in the Extended Class)	A member of the CNO who is a registered nurse in the extended class can order the application of soundwaves for diagnostic ultrasound.	Yes

Member of the College of Nurses of Ontario (other than a member who is a Registered Nurse in the Extended Class)	A member of the CNO who is not a registered nurse in the extended class cannot order the application of soundwaves for diagnostic ultrasound.	Yes, but only if the member has a therapeutic nurse-patient relationship with the person to whom the soundwaves are being applied and the soundwaves are being applied for conducting one or more routine nursing assessments of a patient to assist in the development/ implementation of the patient's plan of care and only if the conditions set out in the Regulation are met.[1]
Member of the College of Medical Radiation Technologists of Ontario	A member of the CMRTO cannot order the application of soundwaves for diagnostic ultrasound.	Yes, but only with an order from a health care professional with ordering authority and only if the conditions set out in the Regulation are met.[2]

For more information regarding ordering and applying soundwaves for diagnostic ultrasound, please consult O. Reg. 107/96 or contact the CMRTO.

[1]Section 4.1(1) of O. Reg. 107/96 provides that a member of the CNO, other than a member described in subsection (2), is exempt from subsection 27 (1) of the Act for the purpose of applying soundwaves for diagnostic ultrasound, as long as the member has a therapeutic nurse-patient relationship with the person to whom the soundwaves are being applied and the soundwaves are being applied for the purpose of conducting one or more routine nursing assessments of a patient to assist in the development or implementation of the patient's plan of care. Subsection (2) provides that a member of the CNO who is a registered nurse in the extended class is exempt from subsection 27 (1) of the Act for the purpose of applying, or ordering the application of, soundwaves for diagnostic ultrasound.

The conditions set out in section 7.1(1) of O. Reg. 107/96 also apply in this context. Section 7.1(1) provides that a person is exempt from subsection 27(1) of the Act for the purpose of applying soundwaves for diagnostic ultrasound if the application is ordered by a member with ordering authority, and the soundwaves for diagnostic ultrasound are applied:

(a) in a site of a public hospital where the public hospital is approved as a public hospital under the *Public Hospitals Act*, and the equipment is operated by the public hospital;

(b) in a private hospital operated under the authority of a licence issued under the *Private Hospitals Act* and the equipment is operated by the private hospital;

(b.1) in the University of Ottawa Heart Institute, and the equipment is operated by the University of Ottawa Heart Institute;

(c) in an independent health facility licensed under the *Independent Health Facilities Act* in respect of diagnostic ultrasound on a site for which that independent health facility is licensed in respect of diagnostic ultrasound; or

(d) in a fixed site where health services are customarily performed, and the application is ordered by a member with ordering authority who treats his or her own patients in the course of his or her health care practice, but only if,

(i) there exists an ongoing professional health care relationship between the patient and the member with ordering authority, or between the patient and a regulated health professional who ordinarily practises with that member at one or more sites in Ontario,

(ii) there exists an ongoing professional health care relationship between the patient and a regulated health professional who has given an opinion on the health of the patient, or between the patient and a regulated health professional who ordinarily practises at one or more sites in Ontario with the regulated health professional who has given the opinion, and the patient has requested that the member with ordering authority confirm, refute or vary that opinion and,

(A) the member orders the application of soundwaves for diagnostic ultrasound in the course of an assessment of the patient resulting from that request, and

(B) the diagnostic ultrasound is directly related to that assessment, or

(iii) there exists an ongoing professional health care relationship between the patient and a regulated health professional who has referred the patient to the member with ordering authority for the purpose of a consultation, or between the patient and a regulated health professional who ordinarily practises at one or more sites in Ontario with the regulated health professional who has made the referral and,

(A) the member conducts an assessment of the patient, and

(B) the diagnostic ultrasound is directly related to that assessment or services arising out of that assessment.

[2]The conditions set out in section 7.1(1) of O. Reg. 107/96 also apply to members of the CMRTO. Please see footnote 1 above for further information. In this section, "member with ordering authority" means:

(a) a member of the College of Midwives of Ontario, with respect to ordering the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound,

(b) a member of the College of Nurses of Ontario who is a registered nurse in the extended class, with respect to ordering the application of soundwaves for diagnostic ultrasound, or

(c) a member of the College of Physicians and Surgeons of Ontario, with respect to ordering the application of soundwaves for diagnostic ultrasound.

Decision-making guide for performing a procedure

1 Do I have the legal authority to perform the procedure?

Issues to consider:
- Does the procedure fall under the scope of practice of the profession as defined by the MRT Act?
- Does the procedure contain a Controlled Act, and if so, is the Controlled Act an Authorized Act under the MRT Act?
- Does the procedure contain a Controlled Act that is not authorized to me under the MRT Act, and if so, is there a delegation in place giving me the authority to perform the procedure?

YES → CONTINUE

NO → Do not perform the procedure and take necessary action

2 Do I have the necessary knowledge, skills and judgement to perform the procedure safely, effectively and ethically?

Issues to consider:
- Do I have the necessary education and experience in this area of practice?
- Are all the provisions in place for me to perform the procedure safely under the RHPA, MRT Act, HARP Act, *Public Hospitals Act*, *Independent Health Facilities Act*, *Nuclear Safety and Control Act*, and any other applicable legislation?
- Are all the provisions in place for me to be responsible and accountable for performing the procedure and for managing the outcomes, having considered the known risks to the patient in performing the procedure, the predictability of the outcomes in performing the procedure, whether the management of the possible outcomes are within my knowledge, skill and judgement, and any other factors specific to the situation?

YES → CONTINUE

NO → Do not perform the procedure and take necessary action

3 Is an appropriate order in place giving me the authority to perform the procedure?

Issues to consider:
- Do I have an order from an authorized health professional, either directly or through a medical directive, to perform each component of the procedure including the application of ionizing radiation, or electromagnetism for MRI, or soundwaves for diagnostic ultrasound, or any authorized act or delegated controlled act?

YES → CONTINUE

NO → Do not perform the procedure and take necessary action

4 Have all the conditions set out in the CMRTO Standards of Practice been met?

Issues to consider:
- Has the patient provided informed consent for the procedure?
- Am I able to provide the patient with clear and understandable information and instruction regarding the procedure, and respond to their questions?
- Are all the provisions in place for me to be responsible and accountable for performing the procedure in accordance with the conditions set out in the *Personal Health Information Protection Act*, and the *Health Care Consent Act*?
- Are all the provisions in place for me to be responsible and accountable for performing the procedure in accordance with the conditions set out in the CMRTO Standards of Practice, Code of Ethics and sexual abuse prevention program?

YES → CONTINUE

NO → Do not perform the procedure and take necessary action

PERFORM THE PROCEDURE

College of
Medical Radiation
Technologists of
Ontario

Ordre des
technologues en
radiation médicale
de l'Ontario

mandatory reporting

What you must know about...

Introduction

Mandatory reporting refers to the obligation under the *Regulated Health Professions Act, 1991* (RHPA) and the Health Professions Procedural Code (the Code) for members of the College of Medical Radiation Technologists of Ontario (CMRTO or the College), employers and facility operators to file written reports to the College in a number of circumstances as outlined here. In this publication, "members" refers to all members of the CMRTO; that is, members in all of the five specialties: radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography.

Mandatory reporting is considered an essential professional obligation because it is the best means of ensuring that instances of professional misconduct, incompetence, professional negligence, sexual abuse or concerns regarding incapacity are brought to the attention of the College. It is the responsibility of the College to review or investigate any report in the context of its regulatory role to protect the public from harm.

As health professionals, members also have mandatory duties to report information to named officials or agencies under other pieces of provincial legislation. For example, Section 125(1) of the *Child, Youth and Family Services Act, 2017* outlines the public and professional's duty to report a child in need of protection if they have reasonable grounds to suspect abuse as defined under that Act. These Acts also define to whom health professionals are required to report.

However, this publication is focused solely on the duties that members must fulfill to report actions and behaviours to the College and reports to the College that may be required to be made by others regarding medical radiation and imaging technologists.

Updated October 2018

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Offences, charges and bail conditions

Under section 85.6.1 of the Code, a member must file a written report to the College if the member has been found guilty of an offence or pleads guilty to an offence. An offence is a breach of law that is prosecuted in a court. This includes all findings or admissions of guilt, including but not limited to offences under the Criminal Code, the *Health Insurance Act* and other federal and provincial laws. Members are required to report all findings or admissions of guilt, including those made in other jurisdictions and those for which the member may have received a pardon.

The Registrar will review the report made by the member and determine whether to conduct further investigation into the incident. For example, if the offence is related to the practice of the profession or a member's suitability to practise.

Under section 85.6.4 of the Code, a member must file a written report to the College if the member has been charged with an offence. The report must contain information about every bail condition or other restriction imposed upon, or agreed to, by the member in connection with the charge.

Other professional memberships and findings

Under section 85.6.3 of the Code, a member must file a written report to the College if the member is a member of another body that governs a profession inside or outside of Ontario. A member shall also file a written report to the College if there has been a finding of professional misconduct or incompetence made against the member by another body that governs a profession inside or outside of Ontario.

Reporting by employers, facilities and others

Under section 85.5 of the Code, a report must be sent to the College by a person whenever that person:

- terminates the employment of a member, for reasons of professional misconduct, incompetence or incapacity
- revokes, suspends or imposes restrictions on the privileges of a member, for reasons of professional misconduct, incompetence or incapacity

of the College (available on the Government of Ontario's website, https://www.ontario.ca/laws/regulation/930855).

Both incompetence and incapacity are defined in the Code. Incapacity occurs when a member "is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's practice be subject to terms, conditions or limitations or that the member no longer be permitted to practise."

Incompetence occurs when a member's care of a patient displays "a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted."

Sexual abuse of a patient by a member is defined in the Code and includes: sexual intercourse or other forms of physical sexual relations; touching of a sexual nature; and behaviour or remarks of a sexual nature. For more detailed information please refer to *What you must know about ... sexual abuse.*

Filing a report

Reporting by members

Sections 85.6.1 and 85.6.2 of the Code set out the following requirements for a report made by a member regarding a finding of guilt of an offence or finding of professional negligence or malpractice:

- the report must be in writing and be filed as soon as reasonably practical after the member receives notice of the finding of guilt or finding of professional negligence or malpractice
- the report must include the nature and description of the offence or finding, the date of the finding, name and location of the court which made the finding and a notation of any appeal

The member is required to file an additional report if the status of the finding changes as a result of an appeal.

Section 85.6.4 of the Code sets out the following requirements for a report regarding charges and bail conditions:

- a report must be filed in writing with the Registrar of the College of the member who is the subject of the report

- usually reports must be filed with the appropriate College Registrar within thirty days after the obligation to report arises. However, if there are reasonable grounds to believe that sexual abuse of the same patient will continue or of other patients will occur, or that the incompetence or incapacity of the member will expose a patient to harm or injury, and there is urgent need for intervention, the report must be filed immediately

- the report must contain,

  a. the name of the person filing the report

  b. the name of the member who is the subject of the report

  c. an explanation of the alleged sexual abuse, incompetence or incapacity

- the report may only contain the name of the patient who may have been sexually abused if the patient consents in writing to their name being included in the report

- if a member is required to file a report of sexual abuse because of reasonable grounds obtained from one of their patients, the member must use their best efforts to advise the patient of the requirement to file the report before doing so

Section 85.5 of the Code provides the following rules for submitting a report regarding termination of employment, revocation, suspension or imposition of restrictions on a practitioner's privileges or dissolution of a partnership, health profession corporation or association with a member, in each case, for reasons of professional misconduct, incompetence or incapacity:

- a report must be filed in writing with the Registrar of the College of the member who is the subject of the report

- a report must be filed with the appropriate College Registrar within 30 days after the termination of employment, revocation, suspension or imposition of restrictions on privileges or dissolution of the partnership, health profession corporation or association

Conclusion

In summary, CMRTO members must file a report with the CMRTO Registrar when:

- they have been found guilty, or have pleaded guilty, to an offence
- they have been charged with an offence, including information about any bail conditions or restrictions connected with the charge
- a finding of professional negligence or malpractice is made against them
- the member is a member of another body that governs a profession inside or outside Ontario
- a finding of professional misconduct or incompetence is made against the member by another body that governs a profession inside or outside Ontario
- they have reasonable grounds, obtained in the course of their practice, to believe that a patient has been sexually abused by a member of the CMRTO or by any member of another health regulatory college

Employers, facilities and others must file a report with the CMRTO Registrar when:

- the employment of a member is terminated, revoked or suspended for reasons of professional misconduct, incompetence or incapacity, or if the member resigns to avoid such action, or restrictions are imposed on the privileges of a member for reasons of professional misconduct, incompetence of incapacity, or if the member resigns to avoid such action
- they dissolve a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity, or if the member resigns to avoid such action
- a person who operates a facility has reasonable grounds to believe that a member who practises at the facility is incompetent, incapacitated or has sexually abused a patient
- if a health information custodian takes any disciplinary action against a member because of that member's unauthorized collection, use, disclosure, retention or disposal of personal health information

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Briefing Note

To:	Council		
From:	Linda Gough, Registrar & CEO	**Date:**	November 19, 2018
Subject:	2019 Operational Plan		

This agenda item is for:

- [x] Decision
- [ ] Direction to staff
- [ ] Discussion
- [ ] Information

Included in this section is the draft 2019 Operational Plan, which I have developed from the Strategic Plan 2017 - 2021. This was reviewed by the Executive Committee on November 8, 2018, and amended, and is being referred to Council with a recommendation for approval. The draft 2019 Operational Plan is the basis for the 2019 draft budget.

At the December 7, 2018 Council meeting, Council will review, amend if appropriate, and approve the following:

- The 2019 Operational Plan
- The 2019 Budget

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

2019

Operational Plan

Commitment to Regulatory Excellence

Draft 2

November 19, 2018

375 University Avenue, Suite 300, Toronto, ON, M5G 2J5 tel (416) 975-4353 fax (416) 975-4355 1 (800) 563-5847 www.cmrto.org

The lead person column sets out which of the College senior staff are charged with the initiative, project or activity. For those activities related to the Registrar's contract and succession planning, the President is the lead person. Following is a list of the initials used in this column:

- WR = Wendy Rabbie, President
- LG = Linda Gough, Registrar & CEO
- CM = Caroline Morris, Deputy Registrar
- AH = Annette Hornby, Director of Quality Assurance
- TL = Tina Langlois, Director of Professional Conduct and Internal Legal Counsel
- TS = Toufic El Saifi, Director of Corporate Services
- EU = Elizabeth Urso, Manager of Professional Conduct and Policy

1. Ensure members continue to practice safely, effectively and ethically in a changing health care environment

1.1 Promote patient-centred care and collaborative practice by medical radiation and imaging technologists including effective communications with patients, their families and other health professionals

Item	Initiatives, projects and activities	Year	Lead person
1.1 a	Educate diagnostic medical sonographers of their new accountabilities under the *Medical Radiation Technology Act* and *Medical Radiation and Imaging Technology Act*	2019	LG
1.1 b	Update patient information poster	2019	LG
1.1 c	Update the communication guidelines set out in 'What you must know about.... communicating with patients', with public engagement through the Citizen Advisory Group	2019	LG
1.1 d	Promote members understanding and accountability in delivering patient-centred care in their practice, and communicating with patients and families through practice articles and social media	2019	LG

1.2 Ensure transparent, objective, impartial and fair entry to practice requirements that provide effective public protection

Item	Initiatives, projects and activities	Year	Lead person
1.2 a	Implement on-line application process for all types of applicants	2019	CM
1.2 b	Implement EQual Canada accreditation process as method to approve educational programs, in collaboration with AMRTRC, CAMRT, Sonography Canada, educational institutions, and other regulators and certification bodies	2019	LG/CM
1.2 c	Collaborate with educational institutions and continue with presentations to students and instructors	2019	CM

1.3 Advance the regulatory framework for medical radiation and imaging technologists relative to evolving technologies and practice

Item	Initiatives, projects and activities	Year	Lead person
1.3 a	Monitor amendments to the *Medical Radiation Technology Act* and *Medical Radiation and Imaging Technology Act*, or other legislation, and ensure congruence with the College's standards and guidelines	2019	LG
1.3 b	Continue to implement the College's Transparency Implementation Plan	2019	TL
1.3 c	Participate in CPSO Diagnostic Imaging Task Force to update the IHF Clinical Practice Parameters and Facility Standards	2019	AH
1.3 d	Participate in other reviews of existing or proposed legislation, as requested and appropriate	2019	LG/TL

1.4 Ensure medical radiation and imaging technologists maintain and improve their knowledge, skills and judgement required in changing practice

Item	Initiatives, Projects and Activities	Year	Lead person
1.4 a	Continue to educate members on changes to legislation, standards and guidelines affecting their practice	2019	LG

1.4 b	Continue to educate members on 'What you must know about...performing procedures for medical radiation and imaging technologists' to explain the legislative framework for orders and different forms of energy	2019	LG
1.4 c	Continue to educate members regarding their obligations related to the QA Program	2019	AH

1.5 Reinforce medical radiation and imaging technologists' awareness and understanding of their professional responsibilities and accountabilities

Item	Initiatives, Projects and Activities	Year	Lead person
1.5 a	Update and promote publication 'What you must know about....professional accountability',	2019	LG/TL
1.5 b	Continue to interact with MRTs and DMSs at association conferences and educational days, where appropriate	2019	LG/CM/ AH/TL
1.5 c	Promote updated and translated on-line legislation learning package and quiz for applicants and members, as required. Promote as continuing education or QA resource	2019	AH/TL

2. Enhance the confidence of all stakeholders in the regulation of medical radiation and imaging technologists

2.1 Engage the public in the effective regulation of medical radiation and imaging technologists

Item	Initiatives, Projects and Activities	Year	Lead person
2.1 a	Continue with public consultation section of website for consultation on proposed regulations, by-laws and policies	2019	LG
2.1 b	Collaborate with FHRCO and other health regulatory colleges regarding the FHRCO public engagement strategy	2019	LG
2.1 c	Conduct consultation on communicating with patients with Citizen Advisory Group	2019	LG

2.2 Engage medical radiation and imaging technologists in fulfilling their role in self-regulation

Item	Initiatives, Projects and Activities	Year	Lead person
2.2 a	Continue with public consultation section of website for consultation on proposed regulations, by-laws and policies	2019	LG
2.2 b	Promote role of members in self-regulation through Council election process and new electoral districts	2019	LG
2.2 c	Continue Council members involvement in interacting with members through attendance at conferences and the College's booth	2019	LG/CM AH/TL
2.2 d	Use methods of effective communications to convey medical radiation and imaging technologists' contribution to patient-centred care, such as: videos, practice stories, etc	2019	LG
2.2 e	Continue to provide practice advice to members on request	2019	CM/AH

2.3 Support employers in meeting their obligations with respect to the regulation of medical radiation and imaging technologists

Item	Initiatives, Projects and Activities	Year	Lead person
2.3 a	Continue to promote public register feature of website, and Patient Information Poster to employers	2019	CM/LG
2.3 b	Continue to engage employers at conferences of Ontario Association of Radiology Managers, Independent Diagnostic Clinics Association, Ontario Hospital Association, and others	2019	LG/CM AH/TL
2.3 c	Continue to provide information regarding mandatory reporting obligations as requested	2019	TL

2.4 Enhance understanding among health professionals about the role and regulation of medical radiation and imaging technologists

Item	Initiatives, Projects and Activities	Year	Lead person
2.4 a	Continue to meet and collaborate with other professions regarding regulatory issues affecting medical radiation and imaging technologists (physicians, nurses, dentists, physiotherapists, midwives, chiropractors)	2019	LG
2.4 b	Continue to support and collaborate with other regulators through FHRCO, especially regarding proposed legislative changes to the HARP Act	2019	LG
2.4 c	Continue to participate in CPSO Diagnostic Imaging Task Force to update the IHF Clinical Practice Parameters and Facility Standards for Diagnostic Imaging	2019	AH
2.4 d	Continue to engage with other professions at conferences of Ontario Association of Radiology Managers, Independent Diagnostic Clinics Association, Canadian Association of Radiation Oncology, Ontario Hospital Association, and others	2019	LG/CM AH/TL

3. Contribute and respond to government initiatives to ensure the continued protection of the public

3.1 Participate in the development of public policy and regulatory innovation in the public interest

Item	Initiatives, Projects and Activities	Year	Lead person
3.1 a	Continue with participation and leadership in FHRCO and other RHPA groups	2019	LG &TL
3.1 b	Continue with participation and leadership on Alliance of Medical Radiation (and Imaging) Technologists Regulators of Canada	2019	LG
3.1 c	Be a resource to medical radiation and imaging technologists' associations in other jurisdictions pursuing regulation	2019	LG /TL
3.1 d	Continue to refine performance measurement tools and other accountability measures	2019	LG

3.1 e	Participate in other reviews of existing or proposed legislation, as requested and appropriate	2019	LG
3.1 f	Nurture productive relationships with MOHLTC, HPRAC, FHRCO, CPSO, OFC, Health Quality Ontario	2019	LG/CM/ AH/TL

3.2 Implement regulatory changes effectively and transparently

Item	Initiatives, Projects and Activities	Year	Lead person
3.2 a	Implement regulation of diagnostic medical sonographers including registration, updating QA program, revising by-laws, revising and implementing new electoral districts, etc	2019	LG/CM AH/TL
3.2 b	Implement new *Medical Radiation and Imaging Technology Act* including new logo, new brand standards, updating website and all publications, revising by-laws and corporate notices	2019	LG/CM AH/TL
3.2 c	Implement any amendments to regulations or new regulations under RHPA (*Protecting Patients Act*) as needed	2019	LG /TL

3.3 Facilitate the regulation of diagnostic medical sonographers

Item	Initiatives, Projects and Activities	Year	Lead person
3.3 a	Continue to be a resource to the Ministry regarding the regulatory changes needed to protect the public through the regulation of diagnostic medical sonographers with CMRTO	2019	LG
3.3 b	Continue to collaborate with the OAMRS, Sonography Canada and other stakeholders regarding the regulation of diagnostic medical sonographers with CMRTO	2019	LG
3.3 c	Establish relationships with accreditation and inspection groups for diagnostic medical sonography	2019	LG
3.3d	Process applications from internationally educated sonographers	2019	CM

3.4 Be seen as a valued resource in regulatory change to protect the public

Item	Initiatives, Projects and Activities	Year	Lead person
3.4 a	Participate in MOHLTC's accountability initiatives and Transparency Working Group	2019	LG/CM
3.4 b	Implement the regulation of diagnostic medical sonographers to ensure the protection of the public as directed by the Ministry	2019	LG
3.4 c	Nurture productive relationships with MOHLTC, HPRAC, FHRCO, CPSO, OFC, Health Quality Ontario	2019	LG/CM/ AH/TL

4. Demonstrate excellence in governance and leadership

4.1 Maintain the effectiveness of the College Council and the committees

Item	Initiatives, Projects and Activities	Year	Lead person
4.1 a	Continue to engage with the Public Appointments Office to ensure timely appointment of public members and skillsets to support Council compliment	2019	LG
4.1 b	Continue with transitional Council members for diagnostic medical sonography and prepare for election in 2019	2019	LG
4.1 c	Review Council meeting format and determine whether to continue with educational session prior to each Council meeting	2019	LG
4.1 d	Trends, observations and administration issues shared to ensure that the Council and Committees are apprised regarding inter-connections and policy matters	2019	LG
4.1 e	Continue to update Council and Committee orientation manual	2019	LG
4.1 f	Continue to educate Council members on responsibilities and accountabilities set out in CMRTO policies	2019	LG/TL
4.1 g	Continue to support the development of regulatory governance educational sessions with FHRCO	2019	LG/TL
4.1 h	Continue to support FHRCO Discipline Orientation sessions	2019	TL
4.1 i	Finalize format for electronic agendas for Council and Committees	2019	TS

4.1 j	Continue to support attendance by President and other members of Council at relevant conferences and educational sessions	2019	LG

4.2 Continue the systematic review of governance policies and processes and revise when necessary

Item	Initiatives, Projects and Activities	Year	Lead person
4.2 a	Continue with review and update of policies in accordance with review schedule	2019	TL/EU
4.2 b	Continue with review and update CMRTO bylaws	2019	TL/EU

4.3 Continue to demonstrate regulatory accountability, performance and compliance

Item	Initiatives, Projects and Activities	Year	Lead Person
4.3 a	Continue with balanced scorecard and dashboard reporting tools in accordance with Council direction	2019	LG, CM, AH, TL
4.3 b	Continue with financial and investment reporting to Council	2019	LG
4.3 c	Continue to submit annual reports to Minister of Health and Long-Term Care, the Ontario Fairness Commissioner and others	2019	LG/CM
4.3 d	Continue to meet regulatory obligations related to the registration processes of medical radiation and imaging technologists	2019	CM
4.3 e	Continue to meet regulatory obligations related to quality assurance	2019	AH
4.3 f	Continue to meet regulation obligations related to professional conduct issues	2019	TL
4.3 g	Continue to develop and implement initiatives to strengthen accountability	2019	TL/LG

5. Ensure sufficient organizational capacity

5.1 Maintain an appropriate level of:

- **Finances**
- **Human Resources**
- **Facilities**

Item	Initiatives, Projects and Activities	Year	Lead person
5.1 a	Review HR policies, salary scales and staffing plan annually	2019	LG/CM
5.1 b	Increase staffing complement in accordance with financial plan to complete the regulation of diagnostic medical sonographers	2019	LG/CM
5.1 c	Continue with ongoing budget planning and management, monitor outcomes	2019	LG
5.1 d	Continue with ongoing reserve fund management	2019	LG
5.1 e	Continue with ongoing fee review processes and annual fee determination	2019	LG
5.1 f	Continue with ongoing lease management. Current lease expires in 2019	2019	LG

5.2 Ensure information technology and systems meet regulatory, operational and strategic requirements

Item	Initiatives, Projects and Activities	Year	Lead person
5.2 a	Continue with hardware replacement and upgrade plan	2019	TS

5.2 b	Continue with software upgrades and implementation plan – upgrade to replatform the college register product (CMM) into the cloud environment onto CRM2016 and Adxstudio portals 8.0 versions	2019	TS/CM
5.2 c	Install video conferencing capabilities in Council room and Registrar's office	2019	TS
5.2 d	Replace furniture in all offices to increase # of work stations	2019	TS/LG
5.2 e	Continue with member services improvement plan – electronic elections, QA ePortfolio app, QA alert	2019	TS/CM
5.2 f	Conduct IT security audit and implement recommendations, as appropriate	2019	TS
5.2 g	Research and secure cyber insurance	2019	TS/LG
5.2 h	Complete build and release new CMRITO website	2019	LG/CM/TS
5.2 i	Complete development and implementation of on-line application process for all specialties in 2019	2019	CM/TS

6. Nurture productive relationships to support the mission, vision and strategic goals

6.1 Foster effective relationships with stakeholders and organizations, including:

Item	Initiatives, Projects and Activities	Lead person
6.1 a	Ministry of Health and Long-Term Care (MOHLTC) and its agencies	LG/CM/TL/AH
6.1 b	HealthForceOntario (HFO)	CM
6.1 c	Health Quality Ontario (HQO)	LG
6.1 d	Office of the Fairness Commissioner (OFC)	CM
6.1 e	Federation of Health Regulatory Colleges of Ontario (FHRCO)	LG/TL
6.1 f	Alliance of Medical Radiation (and Imaging) Technologists Regulators of Canada (AMRTRC)	LG
6.1 g	Ontario Association of Medical Radiation Sciences (OAMRS)	LG/CM/TL/AH
6.1 h	Canadian Association of Medical Radiation Technologists (CAMRT)	LG/CM/TL/AH
6.1 i	Ontario Association of Radiology Managers (OARM)	LG/CM/TL/AH
6.1 j	Canadian National Network of the Profession of Medical Radiation Technology	LG

6.1 k	Sonography Canada	LG/CM
6.1 l	Other professional associations	LG/CM/TL/AH
6.1 m	Other regulators	LG/CM/TL/AH
6.1 n	Educational institutions for MRT and DMS programs	CM
6.1 o	Employer groups	LG/CM/TL/AH
6.1 p	Other organizations, agencies, and service providers	LG/CM/TL/AH

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Briefing Note

To:	Council		
From:	Executive Committee	**Date:**	November 19, 2018
Subject:	CMRTO Salary Ranges		

This agenda item is for:

- [X] Decision
- [ ] Direction to staff
- [X] Discussion
- [ ] Information

At its meeting on November 8, 2018 the Executive Committee reviewed the Statistics Canada Consumer Price Index, August 2018 and a recommendation from the Registrar & CEO.

The Executive Committee has forwarded this item on to Council for its consideration. The Executive Committee recommends that the discussion regarding this agenda item be held in an in camera session.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

CIRCULATED WITH AGENDA
OF DEC 0 7 2018
COUNCIL ITEM# 6bii

Report

To:	Council		
From:	Executive Committee	**Date:**	November 19, 2018
Subject:	CMRTO Salary Ranges		

This agenda item is for:

- [X] Decision
- [ ] Direction to staff
- [ ] Discussion
- [ ] Information

In accordance with the provisions set out in Policy 4.8, Salary Ranges for CMRTO Staff and Policy 4.9, Process to Review the Salary Range for the Position of the Registrar & CEO and the Registrar & CEO's Salary, the Executive Committee met on November 8, 2018 regarding the salary ranges and is forwarding a recommendation to Council for consideration and, if appropriate, approval.

Every three to five years, the CMRTO performs a review of the salary ranges of the CMRTO staff using a consulting group with expertise in this area. The review was performed by the Mungall Consulting Group in October – November, 2016. The Mungall Group's findings are that the CMRTO's salary range structure continues to be competitive to market relative to compensation data reported for comparable positions.

The Executive Committee reviewed the salary ranges of the CMRTO staff to consider whether to recommend a change in the salary ranges, having regard to whether there has been a change in the cost of living. The Consumer Price Index, August 2018, rose 2.8% in the 12 months to August 2018.

Recommendation:

It is recommended that an increase be applied to the salary ranges of the CMRTO support staff and directors, effective January 1, 2019, and that the amount of increase be 2.2% for 2019.

It is also recommended that an increase be applied to the salary range of the Registrar & CEO, and also to the salary of the Registrar & CEO and that the amount of the increase be 2.2% for 2019.

The Executive Committee considered the following in making its determination and recommendation:

- The salary review performed by the Mungall Consulting Group in 2016 found that CMRTO's salary ranges for support staff and directors continue to be competitive to market data for comparable positions
- The report from the Mungall Consulting Group recommends that CMRTO salary ranges should be adjusted 1.7% annually in keeping with composite market movement measures as reported by comparator organizations and in publicly available sources, unless otherwise indicated by unusual market volatility, and subject to affordability
- The CMRTO has a number of valued, experienced staff who are at the top of their pay range. The only increase these staff receive is through the adjustment to the salary ranges
- The CMRTO wants to remain competitive with the market and other regulators, and retain experienced and productive staff
- The draft budget for 2019 has been prepared assuming a 2.2% increase in the CMRTO salary ranges for support staff and directors, and the Registrar & CEO.

The Finance and Audit Committee was notified of the Executive Committee's recommendation and the 2.2% increase has been included in the 2019 budget.

Action required:

- **Council to determine whether to approve the recommendation of the Executive Committee**

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Report

To:	Council	**Meeting:**	December 7, 2018
From:	Finance and Audit Committee	**Date:**	November 7, 2018
Subject:	CMRTO 2019 Budget and 2019 – 2021 Financial Plan		

CMRTO staff have prepared the financial budget for 2019 and proposed financial plan for 2019 – 2021 based on the strategic plan and the draft 2019 Operational Plan. On November 7, 2018, the CMRTO Finance and Audit Committee reviewed the draft 2019 Operational Plan and the proposed budget and financial plan.

The Finance and Audit Committee also considered the recommendation of the Executive Committee regarding staff salary ranges and noted that the recommendations are included in the budget.

The Finance and Audit Committee reviewed the draft budget and financial plan, along with the graphs of CMRTO projected reserve funds before projects and after projects.

As Council will recall, it has been determined that the minimum reserve fund be set at $1.6 million. The College's reserve funds are projected to be at $1.6 million at the end of 2018 and $100,000 below the minimum reserve amount at the end of 2019. It is projected that the minimum reserve fund will be replenished by year end 2020.

The Finance & Audit Committee is pleased that the reserve funds remain at the minimum level given the large expenses in 2018 with the regulation of sonographers and the implementation of the MRIT Act in 2019. However, those costs have been offset by the corresponding increase in revenue. The Committee is in agreement that the CMRTO's current financial reserves of over $2.2 million (investments plus cash), support and enable the expenses required for these critical projects in 2019.

Some of the line expenses of the draft budget and financial plan are difficult to predict as the amount of money spent is dependent upon the volume of activities that are outside the College's ability to control (discipline hearings, complaints and reports). It is important the College continue to monitor the Operational Plan and budget on an annual basis, in this way, amendments can be made to the Operational Plan as funds permit.

After discussion, the following resolutions were approved by the Finance and Audit Committee and are now presented to Council for consideration and discussion:

- **Resolved that the 2019 draft budget, be referred to Council with a recommendation for approval.**
- **Resolved that the 2019 – 2021 draft financial plan, be referred to Council with a recommendation for approval in principle.**

Action required:

Review, discussion and, if appropriate, approval.

Draft

College of Medical Radiation Technologists of Ontario
2019 Budget

	YTD Aug 2018	2018 Forecast	2018 Budget	Variance	2019 Budget	Notes
REVENUE						
Membership-related Revenue	2,777,834	4,769,704	4,451,838	317,866	5,211,791	Forecast increase of 49% in membership to 10,500; Plan for 11,000 in 2019
Miscellaneous	431	3,431	-	3,431	-	Professional conduct cost recovery
Interest Income	16,730	20,000	20,000	-	22,000	Plan based on current portfolio includes interest from current account
Total Revenue	2,794,995	4,793,135	4,471,838	321,297	5,233,791	
EXPENSES						
Human Resources	1,438,500	2,296,503	2,224,758	(71,745)	2,683,253	2018 variance (3%) due to temporary staffing and overtime to deal with sonography application processing and new IT position; Plan for 2019 includes 2.6 FTE for compliance & finance roles
Operating Expenses	506,484	867,775	918,858	51,083	940,333	Includes rent, IT support & licenses, bank & credit card fees, printing, travel expenses, postage, telephone, office supplies, insurance
Communication & Legal Fees	402,712	852,782	1,268,439	415,657	1,122,000	Includes communication related to sonography, update publications to include sonography, legal fees related to sonography implementation and new MRIT Act, hearing and investigations costs increase
Education, Q.A. & Other Expenses	108,982	180,600	269,300	88,700	345,600	Includes QA assessments, training expenses, accreditation survey and compensation fund
Governance & Committee Expenses	93,456	165,129	169,925	4,796	197,775	As per Council & committees meeting schedule
Total Expenses Before Capital Projects	2,550,134	4,362,789	4,851,281	488,492	5,288,961	
Impact on Reserve Funds Before Projects	244,861	430,346	(379,443)	809,789	(55,170)	

Draft

College of Medical Radiation Technologists of Ontario
2019 Budget

	YTD Aug 2018	2018 Forecast	2018 Budget	Variance	2019 Budget	Notes
Capital Projects	124,183	292,302	104,000	(188,302)	326,100	College Membership Management (CMM) upgrade, computer hardware & office equipment & furniture
Total Expenses After Capital Projects	2,674,317	4,655,091	4,955,281	300,190	5,615,061	
Impact on Reserve Funds After Projects	120,678	138,044	(483,443)	621,487	(381,270)	Total Revenue less Total Expenses and Projects
Excess of Revenue over Expenses	37,570	61,866	(671,436)	733,302	(423,602)	Match with Statement of Revenue and Expenses (without capital projects)

College of Medical Radiation Technologists of Ontario
2019 - 2021 Financial Plan

Draft

	2018 Forecast	2019 Budget	2020 Budget	2021 Budget	Notes
REVENUE					
Membership-related Revenue	4,769,704	5,211,791	5,241,789	5,291,025	Assume a slight 1% increase in membership for 2020 and 2021
Miscellaneous	3,431	-	-	-	Professional conduct cost recovery
Interest Income	20,000	22,000	26,000	30,000	Interest income increase for 2020 & 2021 due to increase in reserve funds
Total Revenue	4,793,135	5,233,791	5,267,789	5,321,025	
EXPENSES					
Human Resources	2,296,503	2,683,253	2,671,682	2,757,858	As per staffing plan + 1.6% COL for 2020 & 2021
Operating Expenses	867,775	940,333	951,861	964,067	Keep at the same level with a slight increase of some expense lines; average increase of 2.5%
Communication & Legal Fees	852,782	1,122,000	939,000	948,800	Hearing days increased to 5 days contested & 5 days uncontested; investigation costs increased by 20% in 2020 & 2021
Education, Q.A. & Other Expenses	180,600	345,600	344,980	352,194	Keep at the same level with a slight increase of some expense lines
Governance & Committee Expenses	165,129	197,775	197,775	227,775	As per Council & committees meeting schedule
Total Expenses Before Capital Projects	4,362,789	5,288,961	5,105,298	5,250,693	
Impact on Reserve Funds Before Projects	430,346	(55,170)	162,491	70,332	Total Revenue less Expenses
Capital Projects	292,302	326,100	20,300	11,300	As per IT Plan

College of Medical Radiation Technologists of Ontario
2019 - 2021 Financial Plan

	2018 Forecast	2019 Budget	2020 Budget	2021 Budget	Notes
Total Expenses After Capital Projects	4,655,091	5,615,061	5,125,598	5,261,993	
Impact on Reserve Funds After Projects	138,044	(381,270)	142,191	59,032	Total Revenue less Expenses and Projects
Excess of Revenue over Expenses	61,866	(423,602)	(96,881)	(169,827)	Match with Statement of Revenue and Expenses (without capital projects)

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Briefing Note

To:	Council
From:	Linda Gough, Registrar & CEO **Date:** November 19, 2018
Subject:	Diagnostic medical sonographers (DMSs)

This agenda item is for:

- [ ] Decision
- [ ] Direction to staff
- [x] Discussion
- [x] Information

A verbal update on the status of the regulation of diagnostic medical sonographers will be provided at the meeting. Mr. Patrick Descerni, Assistant Deputy Minister, has been invited to attend this portion of the meeting.

Kirusha Kobindarajah

From: CMRTO Communications <communications@cmrto.org>
Sent: September-19-18 2:34 PM
To: Jef Ekins <jef.ekins@cmrto.org>
Subject: You're Invited to CMRTO's Fall Webinar Series

This fall, CMRTO is hosting a series of webinars. We hope you can join us.

Designed for CMRTO members and applicants eager to refresh their knowledge and acquire the most up-to-date information, these free 45-minute webinars cover a host of topics related to the practice of medical radiation and imaging technology in Ontario.

What Happens January 1, 2019? Thursday, September 27, 2018 1:00 pm REGISTER NOW	Effective January 1, 2019, the regulation of diagnostic medical sonography will be fully implemented in Ontario. All sonographers must be registered with CMRTO in order to be legally authorized to practise the profession and to apply soundwaves for diagnostic ultrasound procedures. This webinar will help you understand how the regulation of sonographers by CMRTO affects you and will outline any steps you need to take to ensure that you're ready and able to practice in the new year.
Myths, Rumours & Urban Legends Thursday, October 4, 2018 1:00 pm REGISTER NOW	Join CMRTO Registrar & CEO Linda Gough as she discusses some of the myths, rumours and urban legends about the regulation of medical radiation and imaging technology and answers some of our most commonly asked questions.

Professional Accountability & Getting to Know Your College Thursday, October 11, 2018 1:00 pm REGISTER NOW	What is regulation? What is CMRTO's role in regulating medical radiation and imaging technologists? In this 45-minute webinar, participants will learn about the structure of CMRTO, including Registration, Quality Assurance, and Complaints. Learn more about us and learn what your professional obligations are.

Click on the links above to register for these learning sessions, and stay tuned for more informative webinars from CMRTO later this fall.

Thank you,

CMRTO Communications

College of Medical Radiation Technologists of Ontario
375 University Avenue, Suite 300
Toronto, Ontario, M5G 2J5
tel 416.975.4353 1.800.563.5847
fax 416.975.4355
email communications@cmrto.org
www.cmrto.org

Have any questions about this email? Contact communications@cmrto.org

Kirusha Kobindarajah

From: Linda Gough, CMRTO Registrar & CEO <communications@cmrto.org>
Sent: October-18-18 10:08 AM
Subject: Urgent update for all sonographers: You cannot work effective January 1, 2019 if you are not REGISTERED with CMRTO

To all sonography applicants and CMRTO members,

The deadline for all sonographers to be registered with CMRTO in order to be able to practise in Ontario is less than three months away.

Effective January 1, 2019, your employer will not be able to schedule you to work as a sonographer or apply soundwaves for diagnostic ultrasound unless and until you are registered with CMRTO.

On January 1, 2019, anyone wishing to practise diagnostic medical sonography must be registered with the CMRTO to do so legally in the province of Ontario. Anyone practising diagnostic medical sonography without being registered with the CMRTO could be subject to a fine, professional sanctions and/or provincial offence charges.

As well, changes to the Controlled Acts regulation made under the *Regulated Health Professions Act* come into force on the same date. Effective January 1, 2019, only members of the CMRTO, College of Physicians and Surgeons of Ontario, College of Nurses of Ontario and College of Midwives of Ontario will be authorized to perform the controlled act of applying soundwaves for diagnostic ultrasound examinations. As a result, if you or anyone you know is currently practising or hopes to practise diagnostic medical sonography in Ontario after January 1, 2019, it is critical to apply for registration immediately to avoid delay or prosecution.

In order to ensure that all sonographers currently working in Ontario are able to work on January 1, 2019, CMRTO recommends that you submit your application to CMRTO no later than November 16, 2018, and complete the registration process no later than December 15, 2018.

We cannot guarantee that we can process applications submitted after November 16, 2018 in time for applicants to become registered as sonographers by December 31, 2018.

For the past ten months, CMRTO has been informing sonographers of the January 1, 2019 deadline, and staff have been helping diagnostic medical sonographers apply to and register as members of CMRTO. The application review and approval process may take up to four months for CMRTO to complete, as evaluating each applicant's skills, experience and education to determine if they meet the registration requirements outlined in the regulation made under the *Medical Radiation Technology Act* (MRT Act) is a complex and time-intensive process. While our staff will continue to do everything possible to process applications in a timely manner, we cannot guarantee that any applications submitted after the November 16, 2018 deadline will be processed in time for applicants to be registered and able to work on January 1, 2019.

We are pleased to report that, as of October 15, 2018, a total of 2,705 diagnostic medical sonographers have either been approved for registration or have already registered with the CMRTO! This is a considerable accomplishment representing over 71% of the applications received at this point. However, there are still 457 applications submitted and waiting for review, and another 616 under review, waiting for information or being referred to the Registration Committee. Our expert staff are working overtime and want to make sure that all eligible applicants currently practising in Ontario are legally able to work by the end of the year – but you have to help us by getting your applications in, or helping your colleagues get their applications in, by the administrative deadline of November 16, 2018.

Once your application has been reviewed, you will be notified about the status of your application. If any additional information is required, you will be notified as soon as possible.

To start your application now, or to complete your already-started application, please click here. For more details on the application process and requirements for registration, please review our application guide by clicking here.

Thank you all for your attention to this important regulatory change.

Sincerely,

Linda Gough, MRT(R) Registrar & CEO

College of Medical Radiation Technologists of Ontario
375 University Avenue, Suite 300
Toronto, Ontario, M5G 2J5
tel 416.975.4353 1.800.563.5847
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Have any questions about this email? Contact communications@cmrto.org

Kirusha Kobindarajah

From: CMRTO Communications <communications@cmrto.org>
Sent: October-19-18 3:19 PM
To: Jef Ekins <jef.ekins@cmrto.org>
Subject: CMRTO Fall Information Sessions

This fall, join Registrar & CEO Linda Gough as she travels across the province to deliver information sessions to CMRTO members and applicants. Topics for these free sessions will include: orders for imaging and therapeutic procedures, the regulation of diagnostic medical sonographers, new electoral districts and expected changes to CMRTO's name and visual identity.

Learn more about your CMRTO, network with other CMRTO members and ask your most pressing questions about the regulation of medical radiation and imaging technologists at these informative sessions. Make plans now to join Linda for an evening of light refreshments and practical information (that can also count towards your continuing education activities) in the following cities:

These information sessions are free for CMRTO members and applicants. No registration is required.

For more information and updates about these upcoming information sessions, please visit the CMRTO website and follow us on Twitter, Facebook and LinkedIn.

Thank you,

CMRTO Communications

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College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

CMRTO Information Workshops Fall 2018

City	Date & Time	Location
Ajax	Monday Oct. 29, 2018 7:00-9:00 p.m.	Ajax Convention Centre 550 Beck Crescent Room: Westney Ballroom, Main Level
Ottawa	Tuesday Oct 30, 2018 7:00- 9:00 p.m.	Ottawa Conference and Event Centre 200 Coventry Rd Room: Lecture Room 110, Main Floor
Thunder Bay	Thursday Nov 1, 2018 7:00-9:00 p.m.	Valhalla Inn 1 Valhalla Inn Road Room: Ballroom
Toronto	Monday Nov 5, 2018 7:00-9:00 p.m.	The Michener Institute for Applied Health Sciences 222 St. Patrick Street Room: Auditorium, Ground Floor
Hamilton	Tuesday Nov 6, 2018 7:00-9:00 p.m.	Carmen's Banquet Centre 1520 Stone Church Road East Room: Venetian Ballroom
Sudbury	Monday Nov 12, 2018 7:00-9:00 p.m.	Holiday Inn Sudbury 1696 Regent Street Room: Georgian Room D
Brampton	Tuesday Nov 13, 2018 7:00-9:00 p.m.	Courtyard Marriott Toronto Brampton 90 Biscayne Crescent Room: Windsor B
London	Wednesday Nov 14, 2018 7:00-9:00 p.m.	Four Points by Sheraton London 1150 Wellington Road South Room: Balmoral A, Mezzanine Floor, Main Entrance

- Workshops are free for CMRTO members and sonographers. No registration is required.
- Light refreshments will be available.
- Rooms may change on actual day. Check with venue on arrival.

Record of Attendees at CMRTO Workshops

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

	Spring 2010	Fall 2011	Fall 2013	Fall 2014	Fall 2015	Fall 2017	Spring 2018	Fall 2018
Location & Topic	Interprofessional Collaboration	Scope of Practice, Authorized Acts, Standards of Practice	ePortfolio, PLI	Patient Communication Guidelines	Professional Accountability	Regulation of Sonographers (# of sonographers)	Registration of DMSs (#of sonographers)	WYMKA... Performing procedures for MRITs
Barrie	33	32	27	27	16	27 (24)	12 (5)	-
Hamilton	26	54	67	52	16	28 (25)	16 (13)	15
London	26	43	73	33	20	21 (19)	7 (3)	20
Oshawa/Ajax	53	62	45	61	54	45 (13)	28 (18)	27
Ottawa	19	43	44	45	27	38 (32)	12 (11)	16
Sudbury	38	22	20	26	19	36 (12)	12 (3)	11
Thunder Bay	21	18	25	53	22	21 (10)	10 (5)	15
Timmins	20	16	14	4	6	----	24 (OTN)	-
Toronto	75	72	72	108	49	62 (36)	43 (36)	50
Windsor	6	----	48	23	28	23 (20)	4 (1)	-
Kingston	----	36	28	25	17	16 (10)	9 (6)	-
Brampton	----	----	----	----	----	30 (27)	26 (22)	38
Workshop Total	**317**	**398**	**463**	**457**	**274**	**347 (228)**	**203 (123)**	**192**
Other Presentations						277 (231)	561	2378
Total	**317**	**398**	**463**	**457**	**274**	**624 (459)**	**764**	**2570**

Last updated: November 26, 2018

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Record of Attendees at CMRTO Workshops

List of other presentations

Date	Location	No of participants
February 22, 2018	CMRTO Webinar: Regulation of sonography – Sonography is being regulated, now what?	209
March 1, 2018	St. Michael's Hospital, Toronto	62
March 22, 2018	Hospital for Sick Children, Toronto	18
March 22, 2018	CMRTO Webinar: Applying and Registration of DMSs	157
May 26, 2018	Sonography Canada Conference, St. Johns	115
Total		**561**

Date	Location	No of participants
September 27, 2018	CMRTO Webinar: What happens January 1, 2019?	420
October 4, 2018	CMRTO Webinar: Myths, Rumours & Urban Legends	331
October 11, 2018	CMRTO Webinar: Professional Accountability & Getting to know your College	355
October 25, 2018	CMRTO Webinar: CMRTO QA Program	768
November 22, 2018	CMRTO Webinar: What you must know about … mandatory reporting	504
Total		**2378**

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Briefing Note

To:	Council		
From:	Linda Gough, Registrar & CEO	**Date:**	November 23, 2018
Subject:	CMRTO Policy Review		

This agenda item is for:

- [X] Decision
- [ ] Direction to staff
- [ ] Discussion
- [ ] Information

Introduction

On September 18, 2018, CMRTO Council approved By-law No. 60, a consolidated by-law relating to the administration and internal affairs of the College. Certain subsections of By-law No. 60 came into force on October 1, 2018 (along with the repeal of By-law No. 12 on the same date), with the remainder of the by-law coming into force on January 1, 2019 (along with the repeal of By-law No. 4, 9, 11, 13, 23, 28 and 43). Updates to our policy framework is required to align our policies with By-law No. 60.

The *Medical Radiation and Imaging Technology Act, 2017* (MRIT Act) if and when it is proclaimed, will also impact our policy framework. The MRIT Act has significant implications for members of the College and the province's diagnostic medical sonographers:

1. In addition to earlier direction by the government to regulate diagnostic medial sonographers as part of the College, the MRIT Act will change the name of the profession to "medical radiation and imaging technology".
2. The scope of practice of medical radiation and imaging technology will set out the use of soundwaves for the purposes of diagnostic procedures in the Act rather than as a regulation.

3. The College's name will be changed to the College of Medical Radiation and Imaging Technologists of Ontario (CMRITO).
4. The MRIT Act will add "diagnostic medical sonographer" as a title restricted to members of the new CMRITO. In other words, no person other than a member of the CMRITO will be permitted to use that title or hold themselves out as qualified to practise the specialty of diagnostic medical sonography.

The MRIT Act received Royal Assent on December 12, 2017 and is awaiting proclamation. Although it is anticipated that the MRIT Act will come into force on January 1, 2019, this may or may not occur.

A review of the CMRTO policy framework was conducted to determine whether the entire policy framework could be updated once to account for *both* the changes required by By-law No. 60 and those changes that will be required if and when the MRIT Act comes into force.

Attached for your review are edited versions of Council policies in all eleven groupings. To the extent possible, these edits account for both the changes required by By-law No. 60 and those changes that will be required if and when the MRIT Act comes into force.

It is the intent that all proposed changes, if approved, would take effect on January 1, 2019 to coincide with the coming into force provisions of By-law No. 60 and the anticipated coming into force date of the MRIT Act.

Operating Assumptions

A. By-law No. 60

To increase readability, transparency and general organization, By-law No. 60 included a definitions section. To align our policy framework with By-law No. 60, staff replaced those terms used in Council policies with the defined terms in By-law No. 60. These terms include: Councillor, Professional Councillor, Academic Councillor, Publicly-Appointed Councillor and Non-Council Committee Member, among others. For your reference, the definitions section of By-law. No 60 is attached to this briefing note.

B. *The Medical Radiation and Imaging Technology Act, 2017*

Effective January 1, 2018, the CMRTO commenced regulating diagnostic medical sonographers as a fifth specialty. As a result, amendments to the CMRTO's Standards of Practice, Code of Ethics, Jurisprudence Course and Quality Assurance program were approved by Council.

In reviewing our policy framework, staff proceeded under the assumption that Council would also support similar amendments to Council policies. These edits, which reduce the impact of the MRIT Act, are set out in the table below:

MRIT Act Change	Resulting Amendment to Reduce Impact of Change
Changing the name of the College from the College of Medical Radiation Technologists (CMRTO) to the College of Medical Radiation and Imaging Technologists (CMRITO)	Replacing references to the CMRTO with "the College" so that references are accurate under both the MRT Act and the MRIT Act.
Changing the name of the profession from "medical radiation technology" to "medical radiation and imaging technology"	Replacing references to the practice of "medical radiation technology" with the practice of "the profession"
Changing the identification of members from "medical radiation technologists" to "medical radiation and imaging technologists"	Replacing references to MRTs with "members"
Changing the profession specific act from the *Medical Radiation Technology Act, 1991* to the *Medical Radiation and Imaging Technology Act, 2017*	Flagging initial references to the *Medical Radiation Technology Act, 1991* with a footnote that provides that on a date to be named by proclamation of the Lieutenant Governor, the Act would be repealed and that on that date, the *Medical Radiation and Imaging Technology Act, 2017* would come into force. In addition, subsequent references to the Act would be "the Act" as opposed to "the MRT Act" to reduce the need for further housekeeping edits in the future.

It is the intention that should the MRIT Act come into force on January 1, 2019, all policies will reflect the visual identity for the CMRITO as approved by Council. For your reference, the policy template contained in the new brand standards guide is attached to this briefing note.

Existing Council Policies

A. House-keeping Amendments

The house-keeping amendments that reflect the operating assumptions detailed above have been made to each Council policy. To increase readability, these edits have not been tracked in the policies included for your review.

Those house-keeping edits required to the titles of policies have also been made. Amendments to policy titles are tracked via track changes in Policy 0.1, Policy Register and Review Policy, for your reference.

For your reference, the only housekeeping edits that have not been implemented at this time are certain references to the CMRTO's mailing address. These housekeeping edits will have to be implemented in the future, if necessary.

B. Substantive Amendments

In accordance with our usual review process, substantive changes have been tracked via track changes. A substantive change is a change that is not captured by the housekeeping amendments described above. If a substantive change is being proposed, the policy attached for your review will reflect an "Amended Date" of December 7, 2018.

Substantive amendments are being proposed for the following policies. The table below outlines the proposed substantive amendments, along with the rationale for each proposed amendment:

Policy Number	Title	Required Amendment and Rationale
Policy 0.1	Policy Register and Review Policy	This Policy needs to be amended to reflect the changes made to the titles of several policies as a result of the housekeeping amendments discussed above.
Policy 1.3	Staff Vacation and Holidays	The vacation entitlement of CMRTO staff now accrues on January 1 as opposed to the anniversary of the employee's initial employment. An amendment is required so that the Policy reflects the current process.
Policy 1.9	Publication of names of suspended members	In accordance with similar amendments approved by Council at their meeting on March 27, 2018, specific reference to the CMRTO publication *Insights* was amended to reference "the newsletter of the College."
Policy 1.10	Registrar & CEO position description	The regulatory functions section of the Policy has been updated to add the appointment of members to Council.
Policy 2.1	Terms of Reference for the Executive Committee	The Executive Committee has proposed an amendment to the Policy to provide that the Registrar & CEO "shall" attend all meetings of the Committee except for personnel matters relation to the Registrar & CEO and declared by the President to require in camera deliberation.
Policy 2.5	Terms of Reference for the Patient Relations Committee	This Policy specifically provides that the Patient Relations Committee administers the CMRTO's program for funding for therapy and counselling "for eligible persons who were sexually abused by a member." As a result of amendments brought about by the *Protecting Patients Act, 2017*, patients can now apply for funding for therapy and counselling as soon as a

		complaint of sexual abuse is filed. An amendment is required to accurately reflect this change in the eligibility criteria.
Policy 2.7	Terms of Reference for the Registration Committee	This Policy provides that "previous experience with the approved educational program is an asset, but not a requirement" for the position of the Chair. It is being proposed that this statement be removed because no other terms of reference policy speaks directly to eligibility requirements for the chair.
Policy 2.9	Terms of Reference for the Nominating Committee	This Policy has been updated to include the responsibility of the Nominating Committee to review expressions of interest for the position of the Academic Councillor, in accordance with proposed Council Policy 3.3, Appointment of the Academic Councillor.
Policy 2.11	Roles and Responsibilities of the Council	In March 2017, Council approved amendments to CMRTO By-law No. 13 necessary to remove the restriction that the President and Vice-President of CMRTO must be professional members. At the same time, Policy 3.2 and Policy 2.1 were amended to reflect this change. At that time, similar updates required to this Policy were missed. As a result, substantive updates are required to remedy this oversight. Also, given that the transition to the new Council composition set out in By-law No. 60 will occur incrementally over the next three election cycles (2019, 2020 and 2021), it is proposed that the composition section of the Policy be amended to defer to the By-law.
Policy 2.13	Conflict of Interest for Councillors and Non-Council Committee Members	This Policy specifically references By-law No. 13 (which will be repealed on January 1, 2019) and includes an amendment provision stating that the Policy cannot be amended unless corresponding amendments are made to By-law No. 13. It is proposed that this amendment provision be removed to increase flexibility.
Policy 2.14	Risk Management	This Policy was approved in 2016, so it has yet to be reviewed by Council in accordance with the review schedule. Amendments are required to the language of this policy along with the Next Review Date.
Policy 3.1	Faculty member for purposes of the election by-law	Amendments to this Policy are required to reflect the appointment process for the Academic Councilor set out in By-law No. 60.

Policy 3.2	Election procedure for the President and Vice-President	Amendments to this Policy are required to reflect the College's use of Bournoit's Rules of Order, as set out in By-law No. 60.
Policy 4.3	Expense, Honoraria and Claim	This Policy specifically references By-law No. 4 (which will be repealed on January 1, 2019). It is proposed that this reference be removed. It is also proposed that the provision that states that "members who live more than 150 km from the College's head office may choose to travel for the meeting the night before" be amended to permit members who live more than "40 km" from the College's head office to travel for the meeting the night before in order to align the College's Policy with the Ministry's Policy for Publicly-Appointed Councillors.
Policy 7.1	Quality Assurance Portfolio: Percentage of Members	Effective January 1, 2018, the QA Committee approved the QA ePortfolio as the form in which members must record their self-assessments and participation in continuing education or professional development activities. For the period up to and including December 31, 2017, the QA Portfolio included both the ePortfolio and the QA Portfolio (Print Version). An amendment to this Policy is required to reflect this change.
Policy 7.3	Random selection without replacement	Same as Policy 7.1, above.

Proposed New Council Policies

1. Accreditation Surveyors (Draft Policy 6.13)

The accreditation survey teams that assess the approved educational programs' compliance with the requirements of EQual Canada accreditation include a representative from the provincial regulatory body. This surveyor has a dual role: participating as a surveyor and being responsible for informing the other surveyors about the provincial laws regulating the profession, and any special information regarding the provincial education system for the profession.

It is proposed that a policy be added to our policy framework that sets out the role of the accreditation surveyor and the process for the selection and appointment of surveyors to the College's roster of accreditation surveyors. The draft policy is included for your review.

2. Appointment of the Academic Councillor (Draft Policy 3.3)

One of the substantive changes in By-law No. 60 is the appointment of a faculty member from among the members of the College who satisfies the eligibility requirements for the position of the Academic Councillor, replacing the election process provided for in By-law No. 12.

A draft appointment policy has been developed that sets out the procedure for the appointment of the Academic Councillor. The draft policy is included for your review. A consequential amendment to Policy 2.9, Terms of Reference for the Nominating Committee, is also being proposed and forms part of the table above.

3. Privacy Code (Draft Policy 10.4)

In 2011, a Privacy Code was developed for the College. The Privacy Code relates to the College's records and information practices. It is being proposed that this Privacy Code form part of the College's policy framework, and that it being reviewed in accordance with the review schedule set by Council.

A draft Privacy Code policy has been developed that also includes the College's procedure for dealing with confidentiality/privacy breaches. As a result, a consequential amendment to the name of policy grouping 10 is required. It is being proposed that the "Information Management" policy grouping be renamed "Privacy and Information Management."

Review by the Executive, Registration and Quality Assurance Committees

At their meeting on November 8, 2018, the Executive Committee reviewed the existing Council policies set out in the agenda, made amendments and resolved to forward the policy package on to Council with a recommendation for approval.

The Executive Committee also reviewed and commented on the Draft Policy 6.13 and Draft Policy 3.3. Amendments suggested by the Executive Committee have been implemented and are reflected in those draft policies attached for your review. Please note that Draft Policy 10.4 was not reviewed by the Executive Committee.

At their meeting on November 14, 2018, the Registration Committee reviewed those policies in the Registration grouping, as well as Policy 2.7, Terms of Reference for the Registration Committee. Given the Committee's workload, the decision was made to defer the review of the Registration Committee policies to 2019.

At their meeting on November 22, 2018, the Quality Assurance Committee reviewed those policies in the Quality Assurance grouping, as well as Policy 2.6, Terms of Reference for the Quality Assurance Committee. The Quality Assurance Committee also reviewed all Quality Assurance Committee level policies and made amendments that align with the house-keeping amendments to Council policies discussed in this briefing note. Those edits will come into effect on January 1, 2019.

Review by Council on December 7, 2018

It is proposed that the Council review the policies set out in the agenda, make any required amendments and then decide:

a) whether to approve the amendments to the existing Council policies effective January 1, 2019, and
b) whether to approve Draft Policy 6.13, Draft Policy 3.3 and Draft Policy 10.4 effective immediately.

By-law No. 60 of the College of Medical Radiation Technologists of Ontario*

Approved Date: September 18, 2018

The by-laws of the College are made in accordance with the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, which authorizes Council to make by-laws relating to the administration and internal affairs of the College.

1. DEFINITIONS

1.1. In the by-laws, unless otherwise defined or required by the context,

1.1.1. "Academic Councillor" means a Councillor who is a Faculty Member appointed to Council in accordance with the by-laws;

1.1.2. "Act" means the *Medical Radiation Technology Act, 1991*;*

1.1.3. "by-laws" means the by-laws of the College;

1.1.4. "Code" means the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991* which forms part of the Act;

1.1.5. "College" means the College of Medical Radiation Technologists of Ontario;*

1.1.6. "committee" means a committee set out in section 10 of the Code or the by-laws or as appointed by Council;

1.1.7. "committee member" means a member of a committee;

1.1.8. "Council" means the Council of the College;

1.1.9. "Councillor" means an Academic Councillor, an Elected Councillor or a Publicly-Appointed Councillor;

1.1.10. "count" includes "tabulate" or "tabulation", depending on whether the word is used as a verb or as a noun;

1.1.11. "debt obligations" means bonds, debentures, banker's acceptances, notes or other similar obligations or guarantees of such obligation, whether secured or unsecured;

* On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiation Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force. As a result, the name of the College of Medical Radiation Technologists of Ontario (CMRTO) will be changed to the College of Medical Radiation and Imaging Technologists of Ontario (CMRITO) and the CMRTO will continue as the CMRITO.

1.1.12. "Elected Councillor" means a member of the Council elected in accordance with this by-law or By-law No.12;

1.1.13. "educational institution" means an institution whose training program is approved by the College;

1.1.14. "Faculty Member" means a person who is a faculty member of an educational institution in the province of Ontario that grants a diploma or degree in the profession;

1.1.15. "fiscal year" means the calendar year;

1.1.16. "instruments in writing" includes, but is not limited to, contracts, documents, deeds, mortgages, charges, security interests, conveyances, transfers and assignments of property, agreements, tenders, releases, receipts and discharges for the payment of money or other obligations and all paper writings;

1.1.17. "mail" means to send by regular postal mail, courier, facsimile or e-mail;

1.1.18. "member" means a member of the College;

1.1.19. "Non-Council Committee Member" means a member who is not a Councillor and who is appointed to serve on a committee in accordance with the by-laws;

1.1.20. "President" means the President of Council and the Chair of the Executive Committee;

1.1.21. "profession" means the profession of medical radiation technology, which includes five specialties: radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography;

1.1.22. "Professional Councillor" means an Elected or Academic Councillor;

1.1.23. "Publicly-Appointed Councillor" means a member of Council appointed by the Lieutenant Governor in Council;

1.1.24. "recount" includes "retabulate" or "retabulation", depending on whether the word is used as a verb or as a noun;

1.1.25. "Register" means the register required by subsection 23(1) of the Code and as further described in the by-laws;

1.1.26. "Registrar & CEO" means the Registrar & CEO of the College as required by the Code and as further described in the by-laws;

1.1.27. "Regulations" means the regulations under the RHPA and the Act;

1.1.28. "RHPA" means the *Regulated Health Professions Act, 1991*;

1.1.29. "RTA" means the *Radiological Technicians Act*;

1.1.30. "Specialty" means a specialty of the profession and includes radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography;

1.1.31. "Specialty Electoral District" means electoral districts 1, 2, 3, 4 and 5, which are established for the purpose of electing members to Council;

1.1.32. "Vice-President" means the Vice-President of Council.

2. HEAD OFFICE

The Head Office of the College shall be in the City of Toronto, in the Province of Ontario, and at a location determined by Council.

3. SEAL

The seal depicted on the right is the corporate seal of the College.

4. COUNCIL

4.1. The Council, established under the Act, shall manage and administer the affairs of the College in accordance with the RHPA, the Act, the Regulations and the by-laws.

4.2. The composition of Council shall be as follows:

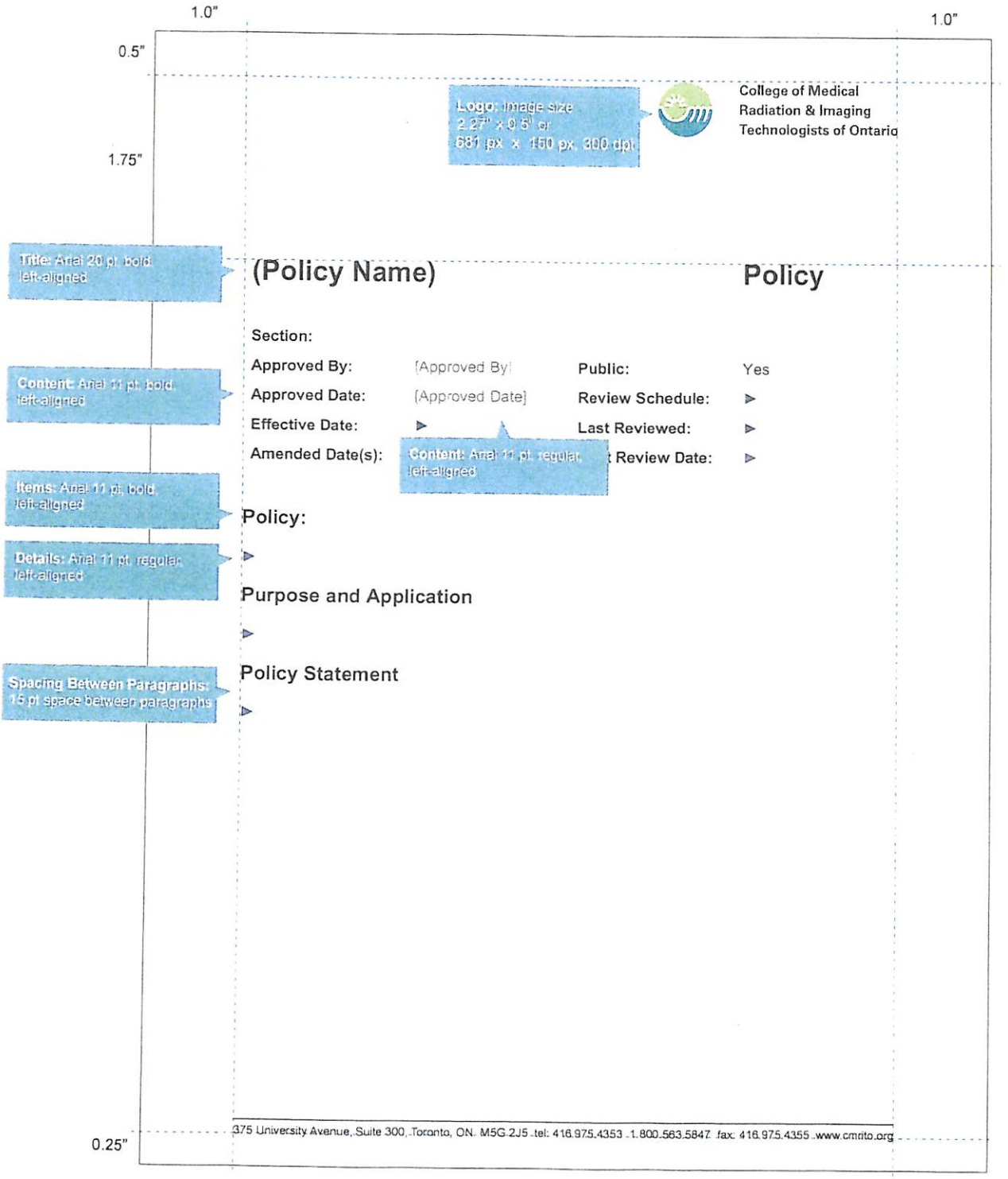
4.2.1. From January 1, 2019 to the first meeting of Council after the April 2019 election, Council shall be composed of:

4.2.1.1. eight (8) Elected Councillors who were elected to the Council in accordance with By-law No. 12, four (4) of whom are from the Specialty of radiography, one (1) of whom is from the Specialty of radiation therapy, one (1) of whom is from the Specialty of nuclear medicine, one (1) of whom is from the Specialty of magnetic resonance, and one (1) of whom is a Faculty Member; and

4.2.1.2. the number of Publicly-Appointed Councillors appointed under the Act;

4.2.2. From the first meeting of Council after the April 2019 election to the first meeting of Council after the April 2020 election, Council shall be composed of:

Policy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College of Medical Radiation & Imaging Technologists of Ontario
Title: Arial 20 pt. bold, left-aligned
(Policy Name)
Policy
Content: Arial 11 pt. bold, left-aligned
Section:
Approved By: [Approved By]
Public: Yes
Approved Date: [Approved Date]
Review Schedule: ▶
Effective Date: ▶
Last Reviewed: ▶
Amended Date(s):
Review Date: ▶
Content: Arial 11 pt. regular, left-aligned
Items: Arial 11 pt. bold, left-aligned
Policy:
Details: Arial 11 pt. regular, left-aligned
▶
Purpose and Application
▶
Policy Statement
Spacing Between Paragraphs: 15 pt space between paragraphs
▶
375 University Avenue, Suite 300, Toronto, ON. M5G 2J5 .tel: 416.975.4353 .1.800.563.5847 .fax: 416.975.4355 .www.cmrito.org

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

DRAFT

Appointment of the Academic Councillor

Policy 3.3

Section:	Election and Appointment		
Approved By:	Council	**Public:**	Yes
Approved Date:	[Approved Date]	**Review Schedule:**	Every 3 Years
Effective Date:	[Effective Date]	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	[Next Review Date]

Policy:

In accordance with the by-laws of the College, one member shall be appointed as the Academic Councillor. For the purpose of this policy, "Academic Councillor" means a Councillor who is a Faculty Member appointed to Council in accordance with the by-laws of the College.

To assist the Executive Committee in making a recommendation to Council with respect to the expressions of interest received for the position of the Academic Councillor, Council has approved the use of a competency-based appointment process.

The following is a summary of the appointment process to be followed for the purposes of appointing the Academic Councillor to the Council in accordance with the by-laws of the College.

Background

1. In accordance with the by-laws of the College, the Academic Councillor shall be appointed by resolution of the Council prior to the first regular meeting of Council after the election to be held in the month of April 2019 and the election to be held in April every third year after that.
2. In accordance with the by-laws of the College, a call for interest will be sent by the Registrar & CEO to all members, no later than 120 days before the date of the appointment.
3. All expressions of interest ("applications") must be received on or before the election date as approved by Council. No other applications will be accepted after that date.

Appointment Procedure

1. The Nominating Committee shall pre-screen all applications and assess whether the applicant meets the Councillor Competencies and Expectations established by Council and the eligibility criteria set out in the by-laws of the College.
2. The Nominating Committee shall forward the applications of all eligible applicants to Executive Committee for further assessment prior to the June Council meeting.
3. The Executive Committee shall further assess all applications submitted against the Councillor Competencies and Expectations established by Council.
4. The Executive Committee shall make enquiries as it deems appropriate.
5. The Executive Committee shall make a recommendation to Council regarding the applications received for the position of the Academic Councillor.
6. The Council shall appoint the Academic Councillor by resolution.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

DRAFT

Accreditation Surveyors

Policy 6.13

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	[Approved Date]	**Review Schedule:**	Every 3 Years
Effective Date:	[Effective Date]	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	[Next Review Date]

Policy:

The programs listed in Schedule 1 to Ontario Regulation 866/93, as amended (the "Registration Regulation") or considered by the Council of the College to be equivalent to a program listed in Schedule 1 to the Registration Regulation are the approved programs in Ontario. Attached as Schedule 1 to this Policy is a current list of the approved programs in Ontario.

Council has determined that each of the programs offered in all of the other provinces which has been accredited by the Conjoint Committee for the Accreditation of Educational Programs in Diagnostic Imaging and Medical Radiation Technologies of the Canadian Medical Association, or of 8872147 Canada Inc., a subsidiary of the Canadian Medical Association, or, as of February 1, 2018, Accreditation Canada, an affiliate of Health Standards Organization (the Approved Accreditation Body), is equivalent to the approved programs offered in Ontario.

The accreditation process provides a method of evaluation through regular visits of trained assessors and evaluation of staff, faculties, curriculum and clinical experience. Accreditation is the public recognition that an educational program has met defined standards.

The assessment of an approved educational program's compliance with the requirements of the Approved Accreditation Body is conducted by an accreditation survey team. The mandate of the survey team is to assess the educational program's compliance with the requirements for accreditation and provide a recommendation for an accreditation status. The survey team reflects the broad perspectives of accreditation and its collective approach. The survey team is assembled by the Approved Accreditation Body for each educational program.

Pursuant to an agreement between the College and the Approved Accreditation Body, the College may appoint a member to the survey team (the "accreditation surveyor").

1.1 The Role of the Accreditation Surveyor

The role of the accreditation surveyor is set out in the agreement between the College and the Approved Accreditation Body.

The accreditation surveyor plays a dual role in the accreditation survey team: the accreditation surveyor participates as a surveyor and is responsible for informing other surveyors about the provincial laws governing the profession, and any special information regarding the provincial education system for the profession.

1.2 The Selection and Appointment of Accreditation Surveyors

Members who are interested in acting as accreditation surveyors seek appointment on a voluntary basis.

Members are appointed to the College's roster of accreditation surveyors by the Executive Committee.

The selection of accreditation surveyors to a particular survey team is done by the Approved Accreditation Body in consultation with the College.

DRAFT

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Privacy Code Policy 10.4

Section:	Privacy and Information Management		
Approved By:	Council	**Public:**	No
Approved Date:	[Approved Date]	**Review Schedule:**	Every 3 Years
Effective Date:	[Effective Date]	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	[Next Review Date]

Policy:

The College was established by the *Medical Radiation Technology Act, 1991* (the Act).[1] The legal powers and duties of the College are set out in the *Regulated Health Professions Act, 1991*, (the RHPA) the Health Professions Procedural Code, being Schedule 2 to the RHPA (the Code) and the regulations and by-laws made under the foregoing (together "the Legislation").

In carrying out its objects, the College has a duty to serve and protect the public interest.

In the course of fulfilling its mandate, the CMRTO may collect, use and disclose personal information regarding applicants for membership, members, persons holding themselves out as members, members' patients, persons who may have received services from a person holding themselves out as a member and persons employed, retained, elected or appointed for the purpose of the administration and enforcement of the Legislation. The College's collection, use and disclosure of personal information in the course of carrying out its regulatory activities is done for the purpose of regulating the profession in the public interest.

Persons who are employed, retained or appointed by the College, as well as every Councillor or Non-Council Committee Member, are required by section 36 of the RHPA[2] to keep confidential all information that comes to their knowledge, subject to certain limited exceptions. Breach of this provision by an individual can lead to the imposition of a fine of up to $25,000.00 for a first offence and up to $50,000.00 for a second or subsequent offence. Breach of this provision by a

[1] On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiation Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force.

[2] A copy of section 36 of the RHPA, current to the date referred to therein, is attached as Schedule 1.

corporation can lead to the imposition of a fine of up to $50,000.00 for a first offence and up to $200,000.00 for a second or subsequent offence.

The College is not subject to the federal *Personal Information Protection and Electronic Documents Act* or the provincial *Personal Health Information Protection Act*. The College has voluntarily adopted this Privacy Code to provide a voluntary mechanism through which the College can provide appropriate privacy rights to individuals involved in the College's activities while still enabling the College to meet its statutory mandate under the Legislation.

This Privacy Code and its procedures are administered in accordance with the following principles.

Principle 1: Accountability

The Registrar & CEO is accountable for compliance with this Privacy Code and its procedures. Complaints or questions regarding the manner in which personal information is being handled by the College should be directed to the Registrar & CEO directly by mail or by phone.

The College will provide orientation and training to all new employees, appointees, Councillors and Non-Council Committee Members regarding their obligations pursuant to section 36 of the RHPA and this Privacy Code.

The College's policies regarding privacy and information management are available on the College's website and by request by mail or by phone.

Principle 2: Identifying Purposes

The purpose for which the College collects, uses and discloses personal information is to administer and enforce the Legislation.

The purposes for which the College collects and uses personal information include the following:

- to assess whether an applicant meets the standards of qualification to be issued a certificate of registration;
- to assess whether a member continues to meet the standards of qualification for a certificate of registration;
- to notify a member of their annual renewal of registration;
- to investigate complaints regarding the conduct or actions of a member;
- to investigate whether a member has committed an act of professional misconduct or is incompetent and to resolve such matters including through the imposition of a specified continuing education and remediation program and through undertakings;
- to inquire into whether a member is incapacitated;

- to negotiate and implement informal resolutions, including acknowledgments and undertakings and specified continuing education and remediation programs;
- to hold a hearing of allegations of a member's professional misconduct or incompetence or of allegations that a member is incapacitated;
- to monitor a member's practice in accordance with an order issued by a committee of the College or an undertaking or agreement with the College;
- to carry out the quality assurance program of the College, including an assessment of the records and practice of its members;
- to administer the program established by the College to provide funding for therapy and counselling for eligible persons;
- to investigate reports filed about members of the College under the Code;
- to assess whether a former member's certificate of registration should be reinstated;
- to investigate whether an individual is practising the profession, using protected titles or holding themselves out as qualified to practise the profession, without legal authority;
- to carry out reviews and audits of its practices and processes;
- to develop and provide statistical information for the purpose of human resource planning and demographic, research and other studies including providing information to the Ministry of Health and Long-Term Care and other appropriate agencies;
- to maintain records for the proper functioning to the CMRTO and to communicate with persons;
- to communicate with and provide information to members including the electronic delivery of information;
- to circulate proposed amendments of regulations and by-laws for input by members and stakeholders;
- to conduct member surveys;
- to review prospective candidates for individuals to be retained, elected or appointed to administer the Legislation and to retain or appoint such persons;
- to maintain records to ensure accurate remuneration and payment of expenses, and all documentation require by law and by the various levels of government in accordance with generally accepted accounting principles; and
- to administer or enforce the Legislation.

The College may collect personal information for these purposes from applicants, potential members, members, patients and other persons, such as employers and colleagues. Personal information is collected by the College from time to time and at regular intervals.

The College discloses personal information only as permitted by section 36 of the RHPA or as require by law. For example, the College is required under the Code to maintain a register containing information about its members. The Code requires the College to post the information designated as public on the College's website and to provide access to designated information to a person who requests it. Another example of permissible disclosure of personal

information is that hearings of the Discipline Committee are required, subject to certain exceptions, to be open to the public. Evidence at a hearing of the Discipline Committee may include personal information regarding the member of the College who is the subject of the allegation of professional misconduct or incompetence, as well as personal information regarding the member's patients related to the allegations of professional misconduct or incompetence.

Where personal information is collected for one regulatory purpose, the College has the right to use and disclose the information for another regulatory purpose.

Principle 3: Consent

The College collects personal information for purposes related to its objects,[3] including for the purpose of the proper administration and enforcement of the Legislation and for other related regulatory purposes. In carrying out its objects, the College has a duty to serve and protect the public interest. Obtaining consent of an individual would, in many cases, defeat the purposes of the College collecting, using and disclosing the personal information. Personal information will only be collected, used and disclosed without the knowledge and consent of an individual for the purpose of the administration or enforcement of the Legislation and in accordance with any applicable provision(s) of the Legislation.

Principle 4: Limiting Collection

The College collects only the personal information that is required for the purposes identified in Principle 2 of this Privacy Code and in accordance with the Legislation. The College collects personal information using procedures that are fair and lawful.

Personal information regarding patients must be collected as part of the College's regulatory function. This information is typically obtained by the College as part of an investigation or the administration of the quality assurance program. The focus of these inquiries is the conduct, competence or capacity of the member and the protection of the public. The College only collects personal information regarding patients in connection with its regulatory function.

Principle 5: Limiting Use, Disclosure or Retention

The College does not engage in commercial activity and does not send commercial electronic messages.

[3] The objects of the College are set out in section 3 of the Code.

The College uses personal information only for the purposes identified in Principle 2 and in accordance with the Legislation. Personal information is only disclosed in accordance with section 36 of the RHPA or as required by law.[4]

The College has a record retention policy[5] in place to ensure that personal information that is no longer required to be kept is destroyed, erased or anonymized.

Principle 6: Accuracy

It is in the best interest of the public that the College collect, use and disclose only accurate personal information in regulating the profession. The College therefore uses reasonable efforts to ensure that the information it collects, uses and discloses is accurate.

Members are required to provide the College with current name, contact and employment information and to advise the College of changes within seven (7) days of any change.

Principle 7: Safeguards

The College ensures that the personal information it holds is secure.

The College ensures that personal information is stored in electronic and/or physical files that are secure. Security measures are in place to safeguard this information which includes, but is not limited to, restricting access to personal information, ensuring that physical files are under lock and key and ensuring that electronic files are encrypted or password protected. The College reviews is security measures periodically to ensure that all personal information is secure.[6]

The College will provide orientation and training to all employees regarding the information safeguards required for personal information and their importance.

The College ensures that personal information that is no longer required to be retained is disposed of in a confidential and secure manner.

Principle 8: Openness

The College's privacy and information management policies and procedures are available to the public and its members are available on the College's website and by request by mail or by phone. Inquiries may be directed to the Registrar & CEO.

Principle 9: Access

[4] See Principle 2 for specific examples.
[5] See Council Policy 10.3, Record Retention Policy.
[6] See Council Policy 11.1, Information Security Program.

1. Access

Where the College holds personal information about an individual that forms part of a record created by another organization, the College will refer the individual to the organization that created the record so that the individual may obtain access to the personal information from that organization rather than the College, unless it is appropriate to do so. In all other cases, where the College holds a record of personal information about an individual, upon written request, the College shall allow access to the record to that individual, unless providing access could reasonably be expected to interfere with the administration or enforcement of the Legislation or it is impracticable or impossible for the College to retrieve the record.

For example, situations where access may be denied include:

- the record contains references to another individual(s) that cannot be severed;
- disclosure may result in significant risk of harm to the requester or a third party;
- information in the record was collected or created in the course of an inspection, investigation, inquiry, assessment or similar procedure authorized by law;
- disclosure may defeat the purpose(s) for which the information in the record was collected;
- information in the record cannot be disclosed for legal, security or commercial proprietary reasons;
- information in the record is subject to solicitor-client or other privilege;
- information in the record was generated in the course of a dispute or resolution process;
- the request is frivolous, vexatious, made in bad faith or otherwise an abuse of process.

While the College's response will typically be provided at no cost or minimal cost to the individual, depending on the nature of the request and the amount of information involved, the College reserves the right to impose a cost recovery fee. In these circumstances, the College will inform the individual of the approximate cost to provide the response and proceed upon payment by the individual of the cost.

The College will make reasonable efforts to respond to the request within thirty (30) days and to assist the individual in understanding the information.

Individuals should send their written requests for access, with contact information and sufficient information about themselves to identify them, to the Registrar & CEO by mail.

In the event that the College refuses to provide access to a record of personal information it holds, then the College will provide reasons for denying access. The individual may then choose to file a complaint with the Registrar.

2. Challenging accuracy and completeness of personal information

If the College has granted an individual access to a record of their personal information, the individual has the right to request a correction of what, in their view, is erroneous information in the record. Where an individual is able to successfully demonstrate that personal information of a factual nature (not, for example, the expression of an opinion) is inaccurate or incomplete, the College will amend the information in the record (i.e. correct or add information).

When amending the information, the College will not generally obliterate the original information. Where the record consists of any opinion or observation that has been made in good faith about an individual, the College may refuse to correct the information in the record. In some cases, a correction may be inappropriate (i.e. where the fact that a person made or recorded a statement is the primary focus of the record rather than whether the statement is, in fact, accurate) and the College may refuse to correct the information in the record.

In addition, where appropriate, the College will notify any third parties to whom the College has disclosed the record containing the erroneous information.

Where there is a dispute between the individual and the College as to the accuracy or completeness of the information in the record, then the College will document the details or the disagreement, will permit the individual to prepare a concise statement of disagreement for attachment to the record, and, where appropriate, will make reasonable efforts to advise any third party who received the record containing the contested information from the College, of the unresolved disagreement.

Principle 10: Challenging compliance

Complaints or questions regarding the College's compliance with this Privacy Code should be directed to the Registrar & CEO by phone or by mail.

If the Registrar & CEO cannot satisfactorily resolve a complaint, the College has a formal privacy complaints procedure which includes:

- acknowledging the complaint;
- a review of the complaint by the College's Privacy Committee;
- providing a written decision and reasons to the complainant; and
- taking appropriate measured where the complaint is found to be justified.

Breaches of confidentiality/privacy that are not otherwise the subject of a complaint are dealt with in accordance with the procedure set out in Schedule 2.

Schedule 1

Section 36 of the *Regulated Health Professions Act, 1991*

Currency date: May 1, 2018

Confidentiality

36 (1) Every person employed, retained or appointed for the purposes of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* and every member of a Council or committee of a College shall keep confidential all information that comes to his or her knowledge in the course of his or her duties and shall not communicate any information to any other person except,

(a) to the extent that the information is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*;

(b) in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) to a body that governs a profession inside or outside of Ontario;

(d) as may be required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Health Protection and Promotion Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Long-Term Care Homes Act, 2007*, the *Retirement Homes Act, 2010*, the *Ontario Drug Benefit Act*, the *Coroners Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);

(d.1) for a prescribed purpose, to a public hospital that employs or provides privileges to a member of a College, where the College is investigating a complaint about that member or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in regulations made under section 43;

(d.2) for a prescribed purpose, to a person other than a public hospital who belongs to a class provided for in regulations made under section 43, where a College is investigating a complaint about a member of the College or where the information was obtained by an investigator appointed pursuant to subsection 75 (1) or (2) of the Code, subject to the limitations, if any, provided for in the regulations;

(e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(f) to the counsel of the person who is required to keep the information confidential under this section;

(g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

(h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

(i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons;

(j) with the written consent of the person to whom the information relates; or

(k) to the Minister in order to allow the Minister to determine,

(i) whether the College is fulfilling its duties and carrying out its objects under this Act, a health profession Act, the *Drug and Pharmacies Regulation Act* or the *Drug Interchangeability and Dispensing Fee Act*, or

(ii) whether the Minister should exercise any power of the Minister under this Act, or any Act mentioned in subclause (i).

Reports required under Code

(1.1) Clauses (1) (c) and (d) do not apply with respect to reports required under section 85.1 or 85.2 of the Code.

Definition

(1.2) In clause (1) (e),

"law enforcement proceeding" means a proceeding in a court or tribunal that could result in a penalty or sanction being imposed.

Limitation

(1.3) No person or member described in subsection (1) shall disclose, under clause (1) (e), any information with respect to a person other than a member.

No requirement

(1.4) Nothing in clause (1) (e) shall require a person described in subsection (1) to disclose information to a police officer unless the information is required to be produced under a warrant.

Confirmation of investigation

(1.5) Information disclosed under clause (l) (g) shall be limited to the fact that an investigation is or is not underway and shall not include any other information.

Restriction

(1.6) Information disclosed to the Minister under clause (1) (k) shall only be used or disclosed for the purpose for which it was provided to the Minister or for a consistent purpose.

Not compellable

(2) No person or member described in subsection (1) shall be compelled to give testimony in a civil proceeding with regard to matters that come to his or her knowledge in the course of his or her duties.

Evidence in civil proceedings

(3) No record of a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

Schedule 2

Confidentiality and/or Privacy Breach Procedure

The Registrar & CEO of the College is the person accountable for ensuring that this Privacy Code and its procedures are adhered to.

All College staff members are responsible for notifying the Registrar & CEO immediately in the event of a confidentiality and/or privacy breach.

The Registrar & CEO must take the following steps to address any breach of personal information:

Step 1: Containment

In order to contain the breach, the Registrar & CEO shall:

1. identify the nature of the breach;
2. obtain immediate verbal confirmation of containment; and
3. take steps to obtain written confirmation of confidentiality and the destruction of the information.

Step 2: Evaluation

In order to evaluate the risk(s) associated with the breach, the Registrar & CEO shall assess the personal information that was breached, including:

1. whether the breach disclosed any sensitive personal information, such as financial, health or other information;
2. whether there is a risk of another individual's personal information being breached as a result of the initial breach;
3. whether the breach was a systemic error or a breach of the College's policies or security systems;
4. whether the recipient of the information provided written confirmation of the destruction of the information and provided assurance to keep the information confidential in accordance with Step 1 above; or
5. whether the Registrar & CEO is confident that the recipient of the information will honour their written confirmation.

Step 3: Notification

The Registrar & CEO shall notify the individual(s) that ought to be notified of the breach. This may include staff members, legal counsel (internal and/or external), Councillors, Non-Council Committee Members, members, and/or applicants. In assessing who ought to be notified, the Registrar & CEO shall consider:

a. whether the breach disclosed any sensitive personal information as described above;
b. whether there is a possibility that the breach would endanger an individual's person safety;
c. whether actions need to be taken in order to mitigate any risk(s) resulting from the breach; or
d. whether there is a legislative requirement to notify the individual of the breach.

Step 4: Reporting

The Registrar & CEO shall produce a report regarding the breach, including details of how this procedure was adhered to in responding to the breach.

Step 5: Prevention

In order to reduce the risk of a similar breach occurring in the future, the Registrar & CEO shall:

1. communicate the breach to staff and share the report produced in accordance with Step 4 above, during a staff meeting;
2. remind staff of the importance of ensuring the confidentiality of all personal information, including when mailing, faxing or e-mailing information;
3. remind staff to ensure the accuracy of phone numbers, fax numbers or e-mail address received by telephone and to ensure the accuracy of any such numbers or addresses prior to sending any personal information;
4. remind staff of the mechanisms to ensure the receipt of personal information by the intended recipient in a timely manner; and
5. remind staff that if they are aware that information has not been received by the intended recipient, to immediately commence an investigation into the location of the information and notify the Registrar & CEO in accordance with this procedure.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Policy Register and Review Policy

Policy 0.1

Section:			
Approved By:	Council	**Public:**	No
Approved Date:	June 19, 2015	**Review Schedule:**	Annually
Effective Date:	June 19, 2015	**Last Reviewed:**	September 2018
Amended Date(s):	September 26, 2017 March 27, 2018 September 18, 2018 December 7, 2018	**Next Review Date:**	September 2019

Purpose

The purpose of this Policy is to provide an inventory of the policies of the College and to set out the review schedule of the policies. All current policies of the Council are listed below, along with the review schedule and next review dates. The review schedule is based on the approved date of all policies. Administrative amendments do not impact the review schedule.

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
0.1	Policy Register and Review Policy		Annually	Sept 2018	Sept 2019	N
Administration						
1.1	Customer Service Accessibility Policy	9/23/14	Annually	Sept 2018	Sept 2019	Y
1.2	Social Media Terms of Use	9/23/14	Every 3 Years	Sept 2017	Sept 2020	Y
1.3	Staff Vacation and Holidays	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
1.4	Policy and Program regarding workplace harassment	3/27/15	Annually	Sept 2018	Sept 2019	Y
1.5	Policy and Program regarding violence in	3/27/15	Annually	Sept 2018	Sept 2019	Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
	the workplace					
1.6	Performance Review Process of the Registrar & CEO	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
1.7	Procedures respecting appeals to Council of decisions of Executive Committee made under ~~CMRTO's~~ the Policy and Program regarding workplace harassment or ~~CMRTO's~~ the Policy and Program regarding violence in the workplace	3/27/15	Every 3 Years	Sept 2017	Sept 2020	Y
1.8	Procedures respecting approval of accreditation of ~~MRT~~ educational programs	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
1.9	Publication of names of suspended members	3/27/15	Every 3 Years	Sept 2017	Sept 2020	Y
1.10	Registrar & CEO Position Description	6/15/17	Every 3 Years		Sept 2020	N
1.11	Deputy Registrar	6/15/17	Every 3 Years		Sept 2020	N
1.12	Procedures in the event of the Registrar & CEO's unplanned absence	6/15/17	Every 3 Years		Sept 2020	N
			Governance			
2.1	Terms of Reference for the Executive Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
2.2	Terms of Reference for the Inquiries, Complaints and Reports Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.3	Terms of Reference for the Discipline Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.4	Terms of Reference for the Fitness to Practise Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.5	Terms of Reference for the Patient Relations Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.6	Terms of Reference for the Quality Assurance Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.7	Terms of Reference for the Registration Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.8	Terms of Reference for the Finance and Audit Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.9	Terms of Reference for the Nominating Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.10	Terms of Reference for the Staff Relations Committee	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.11	Roles and Responsibilities of the Council	3/28/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.12	Code of Conduct for Councillors and Non-Council Committee ~~M~~members	9/23/14	Every 3 Years	Sept 2017	Sept 2020	Y
2.13	Conflict of Interest for Councillors and	9/23/14	Every 3 Years	Sept 2017	Sept 2020	Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
	Non-Council Committee Mmembers					
2.14	Risk Management		Every 3 Years		Sept 2020	
Election and Appointment						
3.1	Faculty member for purposes of the ~~election by-law~~appointment of the Academic Councillor	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
3.2	Election procedure for the election of President and Vice-President ~~of the CMRTO~~	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
3.3	Appointment of the Academic Councillor		Every 3 Years			Y
Finance and Risk						
4.1	Significant Accounting Policies	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.2	Financial Plan, Annual Budget and Quarterly Financial Reporting	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.3	Expense, Honoraria and Claim Policy	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.4	Cheque Signing Authority	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.5	Corporate Credit Card	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.6	Executive Limitation Policy	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.7	Investment Policy	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.8	Salary ranges for ~~CMRTO~~ College	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
	staff					
4.9	Process to Review the Salary Range for the Position of the Registrar & CEO and the Registrar & CEO's Salary	12/9/14	Every 3 Years	Sept 2017	Sept 2020	N
4.10	Procurement of Goods and Services Policy	12/9/16	Every 3 Years	Sept 2017	Sept 2020	Y
4.11	Registrar's Discretionary Expenditure		Every 3 Years		Mar 2021	N
		Professional Practice				
~~5.1~~	~~The operation of x-ray tubes in conjunction with nuclear medicine cameras~~	~~3/27/15~~ Revoked 3/27/18	~~Every 3 Years~~	~~Mar 2018~~		~~Y~~
~~5.2~~	~~Bone densitometry~~	~~3/27/15~~ Revoked 3/27/18	~~Every 3 Years~~	~~Mar 2018~~		~~Y~~
5.3	Guidelines for ~~MRTs~~ members for patients found incapable of making treatment decisions under the HCCA	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
5.4	Professional accountability of ~~MRTs~~ members during a work-stoppage	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
		Registration				
6.1	Educational programs and	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
	examination(s) approved by ~~CMRTO~~ the College in radiography, radiation therapy and nuclear medicine					
6.2	Educational programs and examination(s) approved by ~~CMRTO~~ the College in magnetic resonance	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.3	Approved examination in the specialties of radiography, radiation therapy, nuclear medicine and magnetic resonance	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.4	Approved Examination for applicants trained in Quebec	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.5	Course in Jurisprudence set and approved by ~~CMRTO~~ the College ~~– radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography~~	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.6	Employment Specific Certificates	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
	of Registration					
6.7	Approved programs – Cambrian College Magnetic Resonance Program	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.8	Approved programs – Algonquin College Radiography Program	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.9	Approved programs – Fanshawe College Magnetic Resonance Program	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
6.10	Educational programs approved by ~~CMRTO~~ the College in the specialty of diagnostic medical sonography	12/8/17	Every 3 Years		Mar 2021	Y
6.11	Approved examinations for the specialty of diagnostic medical sonography set and administered by Sonography Canada	12/8/17	Every 3 Years		Mar 2021	Y
6.12	Approved examinations for the specialty of diagnostic medical sonography administered by the ARDMS (time-limited)	12/8/17	Time Limited		~~Dec 2018~~	Y
6.13	Accreditation Surveyors		Every 3 Years			Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
Quality Assurance						
7.1	Quality Assurance Portfolio: Percentage of ~~MRTs~~Members	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
7.2	Peer and Practice Assessment by Multi-Source Feedback (MSF) or by an Assessor: Percentage of ~~MRTs~~Members	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
7.3	Random selection without replacement	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
7.4	Continuing education and professional development activities	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
Professional Conduct						
~~8.1~~	~~Notice to Council members respecting discipline hearings~~	~~3/27/15~~ Revoked 3/27/18	~~Every 3 Years~~	~~Mar 2018~~		~~Y~~
8.2	Publication of Discipline decisions	3/27/15	Every 3 Years	Mar 2018	Mar 2021	Y
Human Resources						
9.1	Workplace Health & Safety	9/26/17	Every 3 Years		Sept 2020	N
9.2	Emergency Preparedness & Response	9/26/17	Every 3 Years		Sept 2020	N
9.3	Personal Information Privacy	9/26/17	Every 3 Years		Sept 2020	N
9.8	Leaves of Absence and Sick Time	11/9/17	Every 3 Years		Sept 2020	N
Privacy and Information Management						
10.1	Records and	9/26/17	Every 3		Sept 2020	Y

Policy Number	Title	Approved Date	Review Schedule	Last Reviewed Date	Next Review Date	Public? Yes/No
	Information Management Program Policy		Years			
10.2	Records and Information Management Policy	9/26/17	Every 3 Years		Sept 2020	Y
10.3	Records and Information Retention Policy	9/26/17	Every 3 Years		Sept 2020	Y
10.4	Privacy Code		Every 3 Years			Y
Information Technology						
11.1	~~CMRTO~~ Information Security Program	9/26/17	Every 3 Years		Sept 2020	N

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Customer Service Accessibility Policy

Policy 1.1

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 23, 2014	**Review Schedule:**	Annually
Effective Date:	September 23, 2014	**Last Reviewed:**	September 2018
Amended Date(s):	September 26, 2017	**Next Review Date:**	September 2019

Policy: Customer Service Accessibility Policy

Purpose and Application

Under the *Accessibility for Ontarians with Disabilities Act, 2005* (AODA), all public and private organizations in Ontario must comply with accessibility standards established by regulation. The goal of the AODA is to achieve accessibility for Ontarians with disabilities by January 1, 2025.

This Policy establishes accessibility standards for customer service for the College in accordance with Ontario Regulation 191/11 made under the AODA. This Policy applies to all employees, agents, volunteers, contract staff, Councillors, Non-Council Committee Members and others who deal with members of the public on behalf of the College.

Policy Statement

The College will provide services in a manner that respects the dignity and independence of all persons with disabilities. The provision of services to persons with disabilities will be integrated, unless an alternate measure is necessary to achieve accessibility. Persons with disabilities will be given an opportunity equal to that given to others, to obtain, use and benefit from the services provided by and on behalf of the College. When communicating with a person with a disability, the person's disability shall be taken into account.

Commitment Statement re: Accessible Customer Service

The College is committed to providing its services in a welcoming and accessible environment that respects the dignity, independence, integration and equal opportunity of people with disabilities.

Communication
The College will communicate with persons with disabilities in ways that take into account their disability.

Assistive devices
The College is committed to providing services to people with disabilities who use their own personal assistive devices such as listening devices, wheelchairs, canes, and walkers. Staff will be provided with training on how to assist people who use assistive devices.

Service animals
The College welcomes people with disabilities who are accompanied by guide dogs or other service animals. Service animals are allowed on the parts of our premises that are open to the public.

Support persons
A person with a disability who is accompanied by a support person will be permitted to have that person accompany them on our premises.

Training for Staff
The College will provide training to all employees, agents, volunteers, contract staff, Councillors, Non-Council Committee Members and others who deal with members of the public on behalf of the College. The College will also provide the same training to every person who participates in developing its policies, practices and procedures governing the provision of services to members of the public. Training for new staff will be incorporated in their orientation.

For further details of when AODA training will be provided to all others, please contact the Registrar & CEO to request a copy of the College's AODA Training Curriculum.

Training will be provided on an ongoing basis when there are updates to the legislation, and when changes are made to the College accessible customer service plan and policies. A record of this training will be kept. This record will include the dates on which training was provided, the type of training provided, and the names and number of individuals who attended the training. The College's training will be based on the training resource produced by the Ministry of Economic Development, Trade & Employment entitled: "Accessibility Standard for Customer Service: training resource." This resource may be found at: http://www.mcss.gov.on.ca/en/mcss/programs/accessibility/customerService/trainingResourcesAODA/tableOfContents.aspx

Training will include:

- An overview of the purposes of the AODA and the requirements of the customer service standard
- Instruction about how to interact and communicate with persons with various types of disabilities
- Instruction about how to interact with persons with disabilities who use an assistive device or require the assistance of a guide dog, other service animal or a support person
- Instruction about how to use any assistive devices available on the College's premises
- Instruction about what to do if a person with a particular type of disability is having difficulty accessing the College's services
- Distribution and posting of the College's policies, practices and procedures relating to the customer service standard

Notice of temporary disruption (Appendix A)
In the event of a temporary disruption to particular services or facilities for persons with disabilities, the College will promptly give notice to the public. Its notice will include information about the reason for the disruption, its anticipated duration, and a description of alternative facilities or services, if available. Notice will be posted at the main entrance of the College's head office located at, 375 University Avenue, Suite 300, Toronto ON and may be also be displayed at the location of the disruption, at its reception desk, on its website, in a mailing, or via another reasonable method.

Feedback process (Appendix B)
Questions or feedback about the manner in which the College provides services and programs to people with disabilities, or about the feedback process itself, can be made by contacting the College either in person or via mail, email, electronic storage device, phone or fax. The College will address any accessibility concerns in a timely manner, and as per the process set out in Appendix B.

Definitions (Appendix C)
Appendix A:

Notice of Temporary Disruption to Services or Facilities

The estimated length of the temporary disruption is from

_____to _____

The following services and/or facilities are currently unavailable:

_____due to _____

_____due to _____

The following alternative services and/or facilities are available:

_____

Thank you for your patience in this matter.

For questions or additional information please contact:

Name:

_____

Phone: _____

Fax: _____

Email: _____

Appendix B:

Customer Feedback Form	
We welcome your feedback on the services we provide. Please provide your comments below:	
Please provide information about how we may reply to your feedback: E-mail address: _____ Telephone: _____ Fax: _____ Address: _____ Preferred method of communication: _____	
Date:	Feedback received by:
Please contact us with any further information: **By Telephone:** Telephone 416.975.4353 Toll Free 1.800.563.5847 Fax 416.975.4355 **By Mail:** College of Medical Radiation Technologists of Ontario 375 University Avenue, Suite 300 Toronto, Ontario Canada M5G 2J5 **By Email:** info@cmrto.org	
This feedback is collected under the *Accessibility for Ontarians with Disabilities Act, 2005* (AODA). Feedback is responded to by using the following process: The College's Registrar & CEO will respond to concerns regarding access to College's services and programs by people with disabilities in a timely manner, as per the method of communication identified above. Thank you for taking the time to provide us with feedback on our services.	

Appendix C:

Definitions

Accessible, in relation to customer service, means being easily understood or appreciated; easy to get at; capable of being reached, or entered; or obtainable.

Assistive Device means any device or mechanism that assists a person with a disability in obtaining, using, accessing or benefiting from services provided. Assistive devices may include, but are not limited to American Sign Language (ASL) interpretation, wheelchairs, walkers, canes, assistive listening devices, visual alarms, or assistive software programs.

Disability means:

a. Any degree of physical infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal, or on a wheelchair or other remedial appliance or device,

b. A condition of mental impairment or a developmental disability,

c. A learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

d. A mental disorder,

e. An injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997.*

Guide Dog means a dog trained as a guide for a blind person and having the qualifications prescribed by the regulations made under the *Blind Persons' Rights Act* R.S.O. 1990, c. B.7, s. 1 (1).

Service animal means an animal that provides assistance for a person with a disability. It may be readily apparent that the animal is used by the person for reasons relating to his or her disability; or a person may be asked to provide a letter from a physician or nurse confirming that the person requires the animal for reasons relating to the disability.

Support Person is, in relation to a person with a disability, another person who accompanies him or her in order to help with communication, mobility, personal care or medical needs or with access to goods or services. A support person could be a paid personal support worker, a volunteer, a friend, a family member or other caregiver. A support person does not necessarily need to have special training or qualifications.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Social Media Terms of Use

Policy 1.2

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 23, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	September 23, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy: Social Media Terms of Use

The College uses or may use Facebook, YouTube, LinkedIn, Twitter and other social media tools to share information and to communicate with stakeholders. The College makes reasonable efforts to ensure that content it posts comes from official and approved sources. The College welcomes all comments, opinions, questions, responses and feedback which relate to the College or the issue being discussed, and which comply with these 'Terms of Use'. The College will make reasonable efforts to review comments through regular business hours to ensure that the posted comments are in compliance with the rules and guidelines regarding posting set out in this policy.

Rules and Guidelines regarding Posting

Subject to these Terms of Use, the College will allow comments and other content from users to appear on or through its social media sites, tools or channels submitted or posted by any means through any media, including without limitation the College's Facebook page, Blog, and YouTube channel. Following are the Rules and Guidelines regarding Posting:

- By using the College's social media sites, tools or channels, the user agrees to abide by these Terms of Use
- All references to "comments" in these Terms of Use refer to "comments or content, in whole or in part"
- The College's decisions related to any matter referred to in these Terms of Use shall be made in the College's sole discretion

- The College will make reasonable efforts to delete, or opt not to post, comments that, as determined by the College in its sole discretion, are not related to the College's activities, promote or advertise services or products, or promote or oppose any political party or a person campaigning for elected office, or defame or may defame or otherwise discredit in any manner the College or any other person
- The College will make reasonable efforts to delete comments that contain abusive, vulgar, offensive, threatening or harassing language, personal attacks of any kind, or terms (offensive or otherwise) that target specific individuals or groups, comments that identify a third party, address complaints or compliments about specific members, address an ongoing investigation, make false or unsubstantiated allegations, or may be discriminatory, misleading, defamatory, slanderous or libelous
- The content of all comments may be released into the public domain, so a user should not submit anything they does not wish to be broadcast to the general public
- Users should not post personally identifiable information such as social insurance numbers, addresses or telephone numbers. The College will make reasonable efforts to delete comments containing such information
- The inclusion of links to other sites may result in the relevant comment being deleted
- The College will make reasonable efforts to delete comments that breach or may breach any College by-law, policy or terms of use (including these Terms of Use) or breach or may breach any law, statute, regulation, order, code, standard or rule
- A comment or post may be referred for follow-up within the College's regulatory processes, if required
- Anonymous comments or posts will be deleted

Content removal and other remedies

The College reserves the right at any time without notice to refuse to post comments or to delete comments which the College determines do not comply with these Terms of Use. These Terms of Use are subject to change at any time. Violation of any element of these Terms of Use can lead to restrictions regarding use of the College's social media sites, tools or channels, including without limitation blocking a user from posting, or restricting a user's access, to the College's social media sites, tools or channels.

No remedy herein conferred upon or reserved in favour of the College shall exclude any other remedy existing at law or in equity or by statute, but each shall be cumulative and in addition to every other remedy given hereunder or now or hereafter existing.

The College asks that any user who sees a comment, content or a use that the user thinks does not comply with these Terms of Use notify the College regarding same.

Disclaimers and Agreements

All comments posted are the opinion of the user (writer).

Each user agrees not to upload viruses or other malicious code, and not to facilitate or to encourage any violations of these Terms of Use.

By posting comments, each user gives the College permission to use and distribute those comments. For any comments posted that are covered by intellectual property rights ("IP Content"), the user specifically grants the College the non-exclusive, transferable, sub-licensable, royalty-free, worldwide license to use IP Content in any manner (including without limitation the right to copy, distribute and make derivative works). The user confirms, represents and warrants that the user has the right without restriction to post all comments (including without limitation all links) posted by the user, and that such comments do not abuse or infringe the intellectual property or other rights of any other person.

Each user who submits comments is fully responsible for the comments posted. The College is in no way responsible for such comments nor for any information, references, links, opinions, claims, or advice in such comments, nor to collect, review, use, update, edit, retain, return, dispose of, share, circulate, act on, consider, or respond to, any such comments.

The College in no way verifies or confirms the accuracy of user comments or any aspect of posted content. The College does not review any references or links in any content and is not responsible for any content of any document referred to or in a site to which a link leads.

The College will not correct spelling or grammatical errors.

The College will not automatically 'friend' or 'follow'. A decision to 'friend' or 'follow' a user does not constitute endorsement of comments, content, position, or perspective.

Any sharing or re-tweeting of links on the part of the College does not equate to endorsement.

Social media sites, tools or channels are, or involve third-party service providers for the College which are not affiliated with the College. Users are encouraged to read the terms and conditions of use and the privacy policy of each relevant social media site, tool, channel or third-party service provider.

By using any of the College's social media sites, tools or channels (including without limitation by posting any comment or content), each user agrees to indemnify the College regarding and to hold the College harmless from any liability, loss, damage or expense, including without limitation professional and other fees and expenses, arising out of such user's use of any the College social media site, tool or channel and any comments or content posted.

The College disclaims any liability for any loss or damage resulting from any comments posted. The College's social media sites, tools or channels may not be used for the submission of any

claim, demand, informal or formal complaint, or any other form of legal and/or administrative notice or process, or for the exhaustion of any legal and/or administrative remedy.

Communications to the College made via social media platforms will in no way constitute an official notice to the College or any official or employee of the College for any purpose.

Facebook

The College's Facebook site is not hosted by the College and thus the College's privacy policy does NOT apply. The privacy policy for the College's Facebook site may be found at http://www.facebook.com/about/privacy/. Facebook is a public web site: accordingly, the College disclaims any liability for any loss or damage resulting from any comments posted on the College's Facebook site. A user should not share information such as social insurance numbers, birth dates, or other private information that the user does not want to make available to others. This forum may not be used for the submission of any claim, demand, informal or formal complaint, or any other form of legal and/or administrative notice or process, or for the exhaustion of any legal and/or administrative remedy.

The College manages its Facebook account as a portal for information from the College. However, information posted on Facebook is not official policy of the College and will in no way grant anyone any rights, privileges, or standing on any matter. All information should be verified through official channels at the College. Use of the College's Facebook site is subject to the College's Social Media Terms of Use. For contact information at the College, please check http://www.cmrto.org.

Information about College activities and other methods to communicate with the College are available on the College's official web page. The privacy policy for the College's official web page may also be found there.

Members of the media are asked to pose questions to the College office through their normal channels and to refrain from submitting questions on the College's social media sites as comments. The College can be reached at 416-975-4353.

YouTube

The College's YouTube channel is not hosted by the College and thus the College's privacy policy does NOT apply. The privacy policy for the College's YouTube channel may be found at www.youtube.com/t/privacy_at_youtube. The College retains records of the content on the College portion of the College's YouTube channel, as is provided for in its records retention schedules. These records may include user comments and any personally identifiable information a user shares with the College. A user should not share information such as social insurance numbers, birth dates, or other private information that the user does not want to make available to others. This forum may not be used for the submission of any claim, demand,

informal or formal complaint, or any other form of legal and/or administrative notice or process, or for the exhaustion of any legal and/or administrative remedy. Use of the College's YouTube channel is subject to the College's Social Media Terms of Use.

Information about College activities and other methods to communicate with the College are available on the College's official web page. The privacy policy for the College's official web page may also be found there.

Communications to the College made via social media platforms will in no way constitute an official notice to the College or any official or employee of the College for any purpose.

Members of the media are asked to pose questions to the College office through their normal channels and to refrain from submitting questions on the College's social media sites as comments. The College can be reached at 416-975-4353.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Staff Vacation and Holidays

Policy 1.3

Section:	Administration		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 01, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	September 26, 2017 December 7, 2018	**Next Review Date:**	September 2020

Policy: Staff Vacation and Holidays

Staff Vacation

1. Annual vacations for College staff are mandatory, and vacation entitlement accrues ~~commencing~~ on ~~the anniversary of the employee's initial employment~~January 1.[1] Subject to the balance of this Policy, the maximum vacation allowed during each twelve-month period for each employee is:

Employee type	Year of employment career	Maximum # of vacation days
Associates, administrators and co-ordinators	1st, 2nd, 3rd	15
	4th and subsequent years	20
Directors and managers	1st, 2nd, 3rd	20
	4th and subsequent years	25

2. In addition to the vacation entitlement set out above, subject to the balance of this Policy, each employee will be entitled to the following vacation in each of the eight specific years listed:

All employees	Year of employment career	# of vacation days
	5th	5 (must be taken in the 5th year of employment career)
	10th	5 (must be taken in the 10th year

[1] During an employee's first twelve-months of employment, an employee's vacation entitlement is pro-rated from the commencement date to January 1.

		of employment career)
	15th	5 (must be taken in the 15th year of employment career)
	20th	5 (must be taken in the 20th year of employment career)
	25th	5 (must be taken in the 25th year of employment career)
	30th	5 (must be taken in the 30th year of employment career)
	35th	5 (must be taken in the 35th year of employment career)
	40th	5 (must be taken in the 40th year of employment career)

3. Vacation shall be taken during each twelve-month period regarding which it accrues, other than for exceptional reason approved by the Registrar & CEO.

4. All vacation requests must be made in writing to and approved by the Registrar & CEO or the designated director. Employees are advised to submit their vacation requests well in advance to the Registrar & CEO or the designated director. This enables the Registrar & CEO or the designated director to schedule vacations more effectively. The Registrar & CEO or the designated director will make every effort to accommodate employee vacation requests. However, due to the nature of the College's activities, this is not always possible and each of the Registrar & CEO and the designated director retain discretion to refuse requests where they conflict with the College's operational and staffing needs.

5. Of the vacation entitlement set out in chart 1 above, ten vacation days represent each employee's statutory entitlement and the balance of the days represents additional entitlement from the College. All of the vacation days set out in chart 2 above represent additional entitlement from the College. Any vacation that is taken will apply first towards the statutory entitlement. The additional days (the entitlement from the College) will be lost if not taken. With respect to the additional days (the entitlement from the College), the College does not pay salary in lieu of vacation time not taken.

6. Staff are permitted to take ½ day vacations. To be clear, if an employee elects to take a ½ day of vacation in the afternoon, the hours to be worked are from 8:00 a.m. to 11:30 a.m. with no break period. If an employee elects to take vacation in the morning, the hours to be worked are from 12:30 p.m. to 4:00 p.m. with no break period.

Paid Statutory Holidays

1. The College office is closed on the following statutory holidays: New Year's Day, Family Day, Good Friday, Victoria Day, Canada Day (July 1), Labour Day, Thanksgiving Day, Christmas Day and Boxing Day, as well as the August civic holiday.

2. When New Year's Day, Canada Day, Christmas Day and/or Boxing Day fall on a weekend, the College will reflect common practices in determining which day shall be allowed as holidays.

Float Days

1. The College allows employees two additional floating holidays each year, to be determined by the Registrar & CEO or designated director in consultation with staff.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Policy and Program regarding workplace harassment

Policy 1.4

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Annually
Effective Date:	March 27, 2015	**Last Reviewed:**	September 2018
Amended Date(s):	September 23, 2016 September 26, 2017	**Next Review Date:**	September 2019

Policy and Program regarding workplace harassment

Statement of philosophy

The College has endeavoured to create a work environment in which all people are treated with respect and dignity. The College will not tolerate any acts of workplace harassment by its employees, Councillors, Non-Council Committee Members or non-employees who interact with the College which may include but are not limited to members of the public or a member of the College ("non-employees"). Employees, Councillors and Non-Council Committee Members share a common responsibility for keeping the College's work environment free of workplace harassment.

Purpose of the workplace harassment Policy and Program

The purpose of this Policy and Program is to educate employees, Councillors, Non-Council Committee Members and non-employees as to the types of conduct that can contribute to an unhealthy and unproductive work environment and to ensure, to the extent possible, that a healthy and productive work environment is maintained for all employees of the College. Although this Policy and Program is not punitive in nature, sanctions against individuals may be necessary to achieve the purpose of this Policy and Program.

Definitions and interpretation

This Policy and Program applies to workplace harassment and workplace sexual harassment.

For the purposes of this Policy and Program "workplace harassment" means engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome and includes:

a. conduct which interferes with a climate of understanding and mutual respect for the dignity and worth of each person. Offensive comments or conduct that is known or ought reasonably be known to be unwelcome or to cause insecurity, discomfort, offence or humiliation to another person or group, or
b. when submission to such conduct is made, either implicitly or explicitly, a condition of employment, or
c. when submission to or rejection of such conduct is used as a basis for any employment decision (including, but not limited to, matters of promotion, raise in salary, job security and benefits affecting the employee), or
d. when such conduct has the purpose or the effect of interfering with the person's work performance or creating an intimidating, hostile or offensive work environment.

For the purposes of this Policy and Program, "workplace harassment" also includes, but is not limited to, harassment regarding one or more prohibited grounds as defined by Ontario's Human Rights Code (the Code). For the purposes of this Policy and Program, "prohibited grounds" are race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, record of offences, marital status and family status or disability, as defined by the Code.

For the purposes of this Policy and Program "workplace sexual harassment" means:

a. engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome, or
b. making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome.

For the purposes of this Policy and Program, the term "worker" includes any person who performs work or supplies services to the College for monetary compensation. The term "complainant" includes "complainants" as appropriate in the circumstances, and the term "harasser" includes "harassers" as appropriate in the circumstances.

Wherever the Staff Relations Committee is referred to in this Policy and Program, it shall mean the Executive Committee of the College in its capacity as the Staff Relations Committee.

Types of behaviour which constitute workplace harassment

For the purposes of this Policy and Program, the types of behaviour that constitute workplace harassment and/or workplace sexual harassment include, but are not limited to:

- use of socially unacceptable, profane or derogatory language that would likely result in embarrassment or humiliation for the recipient
- derogatory remarks, verbal innuendo and inappropriate gestures
- inappropriate actions such as pinching, grabbing, hugging, leering, brushing against and touching
- degrading references to appearance
- jokes told or carried out after the joker has been advised that they are embarrassing or offensive, or that are, by their nature, clearly embarrassing or offensive
- the display of or the distribution by mail, fax or electronic means of explicit or otherwise offensive material
- sexually suggestive or obscene comments or gestures
- unwelcome inquiries or comments about a person's sex life
- unwelcome sexual flirtations, advances, propositions
- persistent unwanted contact or attention after the end of a consensual relation
- request for sexual favours
- verbal abuse or threats
- sexual assault
- vexatious conduct, such as constant criticism of work, which is directed at an individual because of one or more prohibited grounds

The question of whether workplace harassment has taken place is determined by the effect of the harassing conduct on the recipient and not the intention of the harasser. *What matters is how the conduct is perceived by the recipient.*

The workplace harassment may be caused by an employee who is in a position of authority, a fellow co-worker, a Councillor, a Non-Council Committee Member or a non-employee. Behaviour may constitute workplace harassment even if it does not occur on the College's premises if it has a negative impact on employment relationships.

A reasonable action taken by the College or a supervisor relating to the management and the direction of workers or the workplace is not workplace harassment.

People covered under the Policy and Program

This Policy and Program applies to all workers, Councillors, Non-Council Committee Members and non-employees and is for the protection of all workers including the Registrar & CEO of the College, and all Councillors and Non-Council Committee Members.

For the purposes of this Policy and Program, workplace harassment includes harassment of an employee by an employee of the College (which includes the Registrar & CEO), a Councillor, a Non-Council Committee Member or a non-employee, which may include but is not limited to

members of the public or a member of the College, which occurs (a) in the working environment or (b) anywhere else as a result of employment responsibilities or employment relationships. It includes, but is not limited to harassment which may occur:

- at the office
- outside the office
- at office related social functions
- in the course of work assignments outside the office
- at work related conferences or training sessions
- during work related travel
- over the telephone

Reporting an incident

The College encourages reporting of all incidents of workplace harassment and workplace sexual harassment, regardless of who the offender may be. Notwithstanding the existence of this Policy and Program, every person continues to have the right to seek assistance from the Ontario Human Rights Legal Support Centre or the Ontario Human Rights Tribunal, even when steps are being taken under this Policy and Program.

If an employee feels that they have been subject to workplace harassment or workplace sexual harassment, the employee may begin by approaching the person in a clear and firm manner to explain that their behaviour is making the employee uncomfortable. In many cases, this is all it takes to solve the problem. The person doing the harassing might not be aware that the behaviour is offensive, and may volunteer to stop it immediately.

However the College recognizes that many employees will not feel comfortable with the above course of action. Accordingly, the employee has the option of making an informal or a formal complaint to the College.

Informal complaint

A person who believes that they have been subject to workplace harassment or workplace sexual harassment may elect to make an informal complaint. An informal complaint should be made to the Registrar & CEO or, in the event the Registrar & CEO is the alleged harasser, to the Staff Liaison Representative, who will be appointed each year by the Staff Relations Committee to serve as a contact for staff members. The recipient of the complaint will work with the complainant to determine if a suitable course of action, with which the complainant is comfortable, can be developed, up to and including converting the complaint into one of a "formal nature".

In most circumstances, no action will be taken by the recipient of the complaint without the knowledge of the complainant and no investigation will result from an informal complaint. The complainant should be aware that the recipient of the complaint will keep a confidential record of the complaint so that future repeat events or patterns can be recognized.

However, situations may arise which are of such a serious nature that the College must take action to protect the complainant, other employees or itself. Accordingly, the College will investigate serious, informal complaints without the complainant's consent where an investigation is appropriate in the circumstances.

Councillors or Non-Council Committee Members who become aware that an employee is being harassed have an obligation to report the information to the Registrar & CEO, or if the Registrar & CEO is the alleged harasser, to the Staff Liaison Representative.

Formal complaint

1. Notification of Appropriate Staff

A person who believes that they have been subject to workplace harassment or workplace sexual harassment may elect to make a formal complaint. A formal complaint should be made to the Registrar & CEO or, in the event the Registrar & CEO is the alleged harasser, to the Staff Liaison Representative.

If the formal complaint is reported to the Staff Liaison Representative, the Staff Liaison Representative must file a confidential report with the Staff Relations Committee. The Registrar & CEO must receive a copy of the confidential report, unless the Registrar & CEO is the alleged harasser.

Any formal complaint reported to or filed with the Registrar & CEO that involves a Councillor or a Non-Council Committee Member must also be filed with the Staff Relations Committee.

If a member of the Staff Relations Committee is the alleged harasser, the member shall not be provided with a copy of the confidential report.

2. Authority to Investigate

The College has a duty to protect its employees from workplace harassment and workplace sexual harassment. The College shall investigate incidents and complaints of workplace harassment that are appropriate in the circumstances.[1]

The Registrar & CEO has the authority to conduct all investigations of workplace harassment or workplace sexual harassment concerning co-employees or non-employees, unless the Registrar & CEO is the alleged harasser. The Registrar & CEO may request the assistance of the Staff Relations Committee or any outside consultant at any stage in the process of the investigation. However, the Registrar & CEO retains the authority to determine and impose the appropriate sanction against the offending employee.

[1] Beginning September 8, 2016, the College has a statutory duty to investigate complaints where an investigation is appropriate in the circumstances pursuant to s. 32.0.7(1)(a) of the *Occupational Health and Safety Act*, R.S.O. 1990, c. O.1.

The Staff Relations Committee shall have the authority to conduct all investigations of workplace harassment or workplace sexual harassment concerning the Registrar & CEO, Councillors or Non-Council Committee Members. The Staff Relations Committee may request the assistance of an outside consultant at any stage in the process of the investigation. However, the Staff Relations Committee retains the authority to determine and impose the appropriate sanction against the offending employee.

3. Description of Misconduct

An accurate record of objectionable behaviour or misconduct is required to resolve a formal complaint of workplace harassment or workplace sexual harassment.

Verbal reports of workplace harassment or workplace sexual harassment must be reduced to writing by either the complainant or the person receiving the complaint, and must be signed by the complainant. A person who believes they have been or currently is being harassed should maintain a record of objectionable conduct in order to effectively prepare and corroborate the complaint.

While the College encourages employees to keep written notes in order to accurately record offensive conduct or behaviour, the College hereby notifies all persons covered by this Policy and Program that, in the event that a law suit or a complaint to the Human Rights Commission develops from the reported incident, the complainant's written notes may not be considered privileged information, and therefore may not be treated as confidential.

4. Time Frame for Reporting Complaint

The College encourages prompt reporting of all complaints so that a rapid response and appropriate action can be taken. However, due to the sensitivity of these complaints and the emotional toll that workplace harassment and workplace sexual harassment may have on a person, no time limit for reporting complaints will be imposed. Late reporting of complaints will not in and of itself preclude the College from taking remedial action.

5. Protection Against Retaliation or Penalty

The College will not in any way retaliate against or penalize a person for:

a. having invoked this Policy and Program (whether on behalf of one's self or another individual), or
b. having participated or co-operated in any investigation under this Policy and Program, or
c. having been associated with the person who has invoked this Policy and Program or participated in these procedures.

As well, the College will not permit the Registrar & CEO or any Councillor, Non-Council Committee Member, employee or non-employee to so retaliate against or penalize another person. Retaliation is a violation of the Policy and Program and the Code, and will be treated in the same manner as workplace harassment. Actions contrary to this provision should be

reported immediately. Any person found to have retaliated against or penalized another person will be subject to the same disciplinary action provided for harassers.

Investigating the complaint

1. The Duty to Investigate

If an investigation is appropriate in the circumstances, an investigation shall be commenced into the incident or complaint of workplace harassment or workplace sexual harassment at issue.

If the Registrar & CEO has the authority to conduct the investigation of the complaint, the Registrar & CEO shall determine whether the conduct complained of, if proven true, would represent workplace harassment or workplace sexual harassment.

If the Staff Relations Committee has the authority to conduct the investigation of the complaint, the Staff Relations Committee (in conjunction with the Registrar & CEO, if appropriate) shall determine whether the conduct complained of, if proven true, would represent workplace harassment or workplace sexual harassment.

If it is determined that the complaint, if proven to be true, does not constitute workplace harassment or workplace sexual harassment, the procedures set out in this Policy and Program will not be applicable. However, the matter may be dealt with by the appropriate parties as a personnel matter.

If it is determined that the complaint, if proven true, would constitute workplace harassment or workplace sexual harassment, an investigation should be conducted according to the following procedures.

2. Identification of Investigator(s)

The Registrar & CEO, or if appropriate, the Staff Relations Committee, will determine who will conduct the investigation. The investigator(s) may be the Registrar & CEO, a member of the Staff Relations Committee, or a consultant engaged by the College to assist in the investigation of the complaint. The investigator(s) will, if possible, include the individual receiving the initial complaint.

3. Confidentiality

The investigator(s) will promptly investigate any reported allegation of workplace harassment or workplace sexual harassment in a timely and fair manner. Privacy and confidentiality will be maintained throughout the investigation to the extent reasonably possible in the circumstances. Disclosure of information obtained about an incident or complaint of workplace harassment, including identifying information about any individuals involved, will not be disclosed unless the disclosure is necessary for the purposes of investigating or taking correct action with respect to the incident or complaint, or is otherwise required by law.

The exact nature of the College's investigation will depend on the particulars of the allegation brought to its attention. During the course of an investigation, the College may seek the assistance of legal counsel and/or the police.

4. Reassignment

If appropriate, the investigator(s) may recommend to the Registrar & CEO a reassignment of work responsibilities or work location, if practical, during the investigation process, to separate the complainant from the alleged harasser.

5. Representation

At any time, the complainant or alleged harasser has the right to be represented by legal counsel or other person of their choice, at their own cost.

6. Investigation Process

Although the investigator(s) will be considerate to the complainant's welfare, the investigations will be thorough. The investigator(s) will inform the alleged harasser about the substance of the complaint and will keep the complainant and the alleged harasser informed about developments as they occur during the investigation. The following is a guideline of steps that may be taken during the investigation process. However, the investigator(s) may vary the process of the investigation, depending on the circumstances:

- Confirm name and position of the complainant
- Identify the alleged harasser
- Confidential interview with the complainant
- Ask the complainant how they responded to the alleged workplace harassment
- Confidential interview with the alleged harasser
- When first interviewing the alleged harasser, remind them of the College's Policy and Program against retaliation for making a complaint of workplace harassment
- Thoroughly ascertain what happened, while asking questions in a non-judgmental manner
- Determine frequency/type of alleged workplace harassment and, if possible, the dates and locations where the alleged workplace harassment occurred
- Find out if there were witnesses who observed the alleged workplace harassment
- Confidential interviews with any witnesses
- Collect written statements from complainant, alleged harasser or potential witnesses
- Develop a thorough understanding of the professional relationship, degree of control and amount of interaction between the alleged harasser and complainant (Does the alleged harasser control compensation, terms of employment or promotions? Do these people work in close proximity to one another or on the same project?)
- Determine whether the alleged harasser has carried out any threats or promises directed at the complainant
- Determine the extent to which the alleged harasser has affected the work product or mental or physical well-being of the complainant in order to determine the need for obtaining appropriate counselling for the complainant

- If appropriate, determine if the complainant knows of or suspects that there are other people who have been harassed by the alleged harasser
- Determine if the complainant has informed supervisors, members of the executive or other Councillors, or anyone else, of the situation and their response, if any
- Ask the complainant what action they would like the College to take in response to any finding of workplace harassment

Resolving the complaint

Upon completion of an investigation, the investigator(s) will communicate the results of the investigation to the Registrar & CEO or, if the Staff Relations Committee has the authority to conduct the investigation, to the Staff Relations Committee.

The Registrar & CEO, or if the Staff Relations Committee has authority to conduct the investigation, the Staff Relations Committee, shall, based on the results of the investigation, determine if workplace harassment or workplace sexual harassment has occurred and the appropriate sanction(s), in accordance with this Policy and Program. The Registrar & CEO, or if applicable, the Staff Relations Committee, shall communicate in writing within 10 calendar days of the investigation being concluded the results of the investigation, including any corrective action that has been taken or that will be taken as a result of the investigation, to the complainant and the alleged harasser, if they are an employee, Councillor or Non-Council Committee Member of the College. This will be done by delivery, if practicable, or by registered mail, if delivery is not practicable. For the purposes of any appeal referred to in this Policy and Program, the decision will be deemed to have been received three days after the decision has been delivered, or seven days after it has been sent by registered mail.

If the Registrar & CEO has the authority to conduct the investigation, the Registrar & CEO has the discretion to report the matter to the Staff Relations Committee or Council or both of them. If the Staff Relations Committee has the authority to conduct the investigation, it has the discretion to report the matter to Council. The report referred to herein may include a statement that an investigation has been conducted, the findings of the investigation, the names of the individuals involved, the decision, or any other information the Registrar & CEO or the Staff Relations Committee considers necessary for the purpose of making the report.

Sanctions

Individuals found to have engaged in misconduct constituting workplace harassment will be sanctioned, up to and including dismissal. Appropriate sanctions will be determined by the Registrar & CEO, with two exceptions. Firstly, if the harasser is a Councillor or a Non-Council Committee Member, the Staff Relations Committee shall determine the appropriate sanction in consultation with the Registrar & CEO. Secondly, if the harasser is the Registrar & CEO, the Staff Relations Committee shall determine the appropriate sanction.

In addressing incidents of workplace harassment, the College's response will, at a minimum, include reprimanding the harasser and preparing a written record. Additional action may include: referral to counselling, withholding of promotion, re-assignment, temporary suspension without

pay, financial penalties, termination or, in the case of a Councillor or Non-Council Committee Member, a determination that the Councillor or Non-Council Committee Member's conduct or actions are detrimental to the College and/or disqualification from sitting on a committee.

Although the College's ability to discipline a non-employee harasser (e.g. client, supplier, Councillor or Non-Council Committee Member) is limited by the degree of control, if any, that the College has over the alleged harasser, any person who has been subject to workplace harassment should file a complaint.

Maintaining a written record of the complaint

The College shall maintain a written record of each complaint and how it was investigated and resolved. Written records shall be maintained in a confidential manner in the office of the Registrar & CEO or legal counsel for the College, as appropriate.

Written records will be maintained for ten years from the date of resolution, unless new circumstances dictate that the file should be kept for a longer period of time.

False accusations

If an investigation results in a finding that the complainant falsely accused another of workplace harassment knowingly or in a malicious manner, the Registrar & CEO will determine the appropriate sanctions to be applied against the complainant, which may include termination of employment.

Appeals

Only a decision of the Staff Relations Committee is subject to appeal. The complainant or the person against whom a finding of workplace harassment has been made, may appeal the Staff Relations Committee's finding regarding workplace harassment or its determination of the appropriate sanction(s) to Council in accordance with procedures established from time to time by Council.

Policy and Program review

This Policy and Program will be reviewed as often as is necessary, but at least annually to foster the College's commitment to protecting its employees from workplace harassment.

Conclusion

The College has developed this Policy and Program to ensure that all its employees can work in an environment free from workplace harassment. The College will make every effort to ensure that all its employees are familiar with the Policy and Program and know that any complaint received will be thoroughly investigated and appropriately resolved.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Policy and Program regarding violence in the workplace

Policy 1.5

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Annually
Effective Date:	March 27, 2015	**Last Reviewed:**	September 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2019

Policy and Program regarding violence in the workplace

Statement of philosophy

The College is committed to the prevention of violence in the workplace, and to maintaining a work environment in which all people are treated with respect and dignity. The College will not tolerate any acts of violence by its employees, Councillors, Non-Council Committee Members or non-employees who interact with the College which may include but are not limited to members of the public or a member of the College ("non-employees"). As employees, Councillors and Non-Council Committee Members, we share a common responsibility for keeping our environment safe and free of violence. The College will take reasonable steps to protect employees and to prevent workplace violence.

A copy of this Policy and Program is included in the Employee Handbook, a copy of which is provided to all employees and is available online through the Human Resources Portal and posted in the staff area. Procedures to address workplace violence such as measures to protect College employees from workplace violence, ways to summon immediate assistance and reporting procedures are also contained in the Employee Handbook.

Definitions and interpretation

For the purposes of this Policy and Program, "workplace violence" means the threat, attempt or exercising of physical force against an employee by an employee of the College, a Councillor, a Non-Council Committee Member or a non-employee, which may include but is not limited to members of the public or a member of the College, which occurs in the working environment or anywhere else as a result of employment responsibilities or employment relationships.

For the purposes of this Policy and Program "violence" means statements or conduct against a worker in the workplace that includes:

a. the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker, or
b. an attempt to exercise physical force against a worker in the workplace, that could cause physical injury to the worker, or
c. a statement or behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

For the purposes of this Policy and Program, the term "worker" includes any person who performs work or supplies services to College for monetary compensation.

A person who has a personal relationship with a worker (such as a spouse or former spouse, a current or former intimate partner or a family member) may physically harm, or attempt or threaten to harm, that worker at work. In these situations, domestic violence is considered workplace violence.

Wherever the Staff Relations Committee is referred to in this policy, it shall mean the Executive Committee of the College in its capacity as the Staff Relations Committee.

People covered under the Policy and Program

All employees, Councillors, Non-Council Committee Members and non-employees are required to act in a manner consistent with this Policy and Program. The violence may be caused by an employee who is in a position of authority, a fellow co-worker, a Councillor, a Non-Council Committee Member or a non-employee. Behaviour may constitute workplace violence even if it does not occur on the College's premises if it has a negative impact on employment relationships.

Workplace violence may occur:

- at the office
- outside the office
- at office related social functions
- in the course of work assignments outside the office
- at work related conferences or training sessions
- during work related travel
- over the telephone

1. Roles and responsibilities

Employees

No employee of the College shall subject any person or persons to workplace violence.

Every employee of the College is expected to review and to comply with this Policy and Program. Compliance includes participation in workplace violence educational and training programs.

The College encourages reporting of all incidents of workplace violence regardless of who the alleged offender may be.

The College

The Registrar & CEO or designated director will ensure that this Policy and Program is implemented and maintained and that all employees have appropriate information and instruction on this Policy and Program.

The Registrar & CEO or designated director will, in consultation with the Staff Relations Committee, conduct regular risk assessments for workplace violence. If necessary, the College will develop, establish and implement new workplace violence prevention measures and procedures.

The Registrar & CEO or designated director will take every reasonable precaution to protect an employee from physical injury if they become aware or believes that domestic violence may occur in the workplace.

The Registrar & CEO or designated director will take all steps that are necessary to respond to workplace violence, including summoning police and/or emergency medical assistance if warranted.

The Registrar & CEO or designated director will also provide employees with support and assistance in dealing with and remedying workplace violence.

The Registrar & CEO or designated director will maintain permanent records of reports and investigations of workplace violence.

Information about a person with a history of violent behaviour

Under the *Occupational Health and Safety Act*, the employer must provide workers with information, including personal information, related to a risk of workplace violence from a person with a history of violent behaviour. This information will be provided to staff of the College if the worker can be expected to encounter that person in the course of their work and the risk of workplace violence is likely to expose the worker to physical injury. The Registrar & CEO or designated director will only disclose as much information as is reasonably necessary to protect the worker from physical injury. Privacy interests will be respected as much as possible.

Domestic violence

College staff should report their concerns if they believe domestic violence will occur in the workplace. The Registrar & CEO or designated director will investigate and deal with these concerns on a case-by-case basis. The measures or procedures may include creating an

individual workplace safety plan in consultation with the staff member, determining how existing measures and procedures can support the employee and developing reasonable precautions for the worker in the circumstances. The Registrar & CEO or designated director will assess whether any further precaution is reasonably required in the circumstances with respect to the protection of the targeted worker and other workers.

Reporting and investigating workplace violence

If an employee feels that workplace violence or the threat of workplace violence has occurred, they should report the incident. Verbal or written complaints can be made to the Registrar & CEO or designated director or, in the event the Registrar & CEO is allegedly responsible for the workplace violence, to the Staff Liaison Representative, who is appointed each year by the Staff Relations Committee to serve as a contact for staff members.

All complaints and incidents of workplace violence will be investigated and dealt with in a timely and fair manner. Privacy and confidentiality will be maintained throughout the investigation to the extent reasonably possible in the circumstances. The exact nature of the College's investigation will depend on the particulars of the allegation brought to its attention. During the course of an investigation, the College may seek the assistance of legal counsel and/or the police.

2. Measures and procedures to control risks identified in workplace violence risk assessment

The College assessed the risk of workplace violence, having regard to:

- circumstances specific to its workplace, including existing security measures, its physical layout, and the fact that there are no reported incidents of workplace violence on file, and
- circumstances that are common to similar workplaces.

This risk assessment (which took into account anonymous questionnaires completed by various College employees) indicates that there is a low risk of violence in the workplace. In light of this risk assessment, the following safety measures and procedures should be followed in the event that workplace violence occurs or is likely to occur:

a. All visitors are required to sign in at reception, and
b. If an employee suspects that an unidentified person is an intruder, the Registrar & CEO or a designated director should be notified immediately.

3. Sanctions

The purpose of this Policy and Program is preventative and remedial. Although this Policy and Program is not punitive in nature, violations will result in appropriate remedial, disciplinary (up to and including termination of employment) and/or legal action. In this context, appropriate action will be determined by the Registrar & CEO, with two exceptions. Firstly, if the person responsible for the workplace violence is a Councillor or a Non-Council Committee Member, the

Staff Relations Committee shall determine the appropriate action in consultation with the Registrar & CEO. Secondly, if the person responsible for the workplace violence is the Registrar & CEO, the Staff Relations Committee shall determine the appropriate action.

The Registrar & CEO, or if applicable, the Staff Relations Committee, shall communicate the decision, including any sanction(s), in writing to the complainant (if applicable) and to the person with respect to whom an allegation regarding responsibility for workplace violence or threat of workplace violence has been made. This will be done by delivery, if practicable, or by registered mail, if delivery is not practicable. For the purposes of any appeal referred to in the Policy and Program, the decision will be deemed to have been received three days after the decision has been delivered, or seven days after it has been sent by registered mail.

4. Appeals

Only a decision of the Staff Relations Committee is subject to appeal. The complainant (if applicable) or the person with respect to whom a determination regarding responsibility for workplace violence or threat of workplace violence has been made, may appeal the Staff Relations Committee's decision regarding responsibility for workplace violence or a threat of workplace violence, or its decision regarding the appropriate sanction(s), to Council in accordance with procedures established from time to time by Council.

5. Protection against Retaliation

Reprisals, retaliation or threats of reprisals against anyone pursuing their rights under this Policy and Program, for having participated or cooperated in an investigation, or for having associated with someone involved in these procedures, are themselves violations of this Policy and Program and will result in disciplinary action up to and including termination of employment.

6. Policy and Program review

This Policy and Program will be reviewed as often as necessary, but at least annually to foster the College's commitment to protecting its employees from workplace violence.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Performance Review Process of the Registrar & CEO

Policy 1.6

Section:	Administration		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 years
Effective Date:	January 1, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	December 9, 2016	**Next Review Date:**	September 2020

Policy

1. Purpose

The purpose of this Policy is to provide a process for an annual performance review of the Registrar & CEO. The objectives of the performance review are to:

a. assess and recognize the performance of the individual in the Registrar & CEO's position with respect to the achievement of the objectives for the previous year and the fulfillment of the responsibilities of the position,

b. identify opportunities for the Registrar & CEO's development or education, and

c. set objectives for the current year.

2. Definitions

"Review Group" means a sub-group of the Executive Committee composed of the President and two other members of the Executive Committee, who have been appointed by the Executive Committee.

3. Responsibilities of the Executive Committee

The responsibilities of the Executive Committee under this Policy are to:

a. establish the Review Group in accordance with the composition described in section 2,

b. approve the annual objectives of the Registrar & CEO in the manner described in section 6, and

c. report to Council on the completion of the performance review process for the Registrar & CEO and the annual objectives for the Registrar & CEO as approved by the Executive Committee.

4. Responsibilities of the Review Group

The responsibilities of the Review Group under this Policy are to:

a. manage the performance review process of the Registrar & CEO,

b. determine the timing and steps of the Registrar & CEO's performance review process for a particular year,

c. prepare any survey(s) or other instruments to solicit input regarding the Registrar & CEO's performance,

d. in accordance with this Policy, solicit the input of Council members, staff and a wider group of individuals who interact with the Registrar & CEO through the completion of a survey or other instruments regarding the Registrar & CEO's performance,

e. collate the results from any survey(s) or other instruments regarding the Registrar & CEO's performance,

f. review the Registrar & CEO's achievements for the previous year and proposed performance objectives for the current year, and

g. meet with the Registrar & CEO to review and discuss the results of the performance review and the proposed performance objectives for the current year.

5. Basis for Performance Review

In the review of the Registrar & CEO's performance, the Review Group considers, as the performance expectations for that year, the Registrar & CEO's position description in combination with the objectives for the current year as approved by the Executive Committee.

6. Setting of Annual Objectives for the Registrar & CEO

a. The Registrar & CEO's annual objectives must align with the ~~CMRTO's~~ College's statutory obligations and its mission, vision and goals, and must take into account ~~CMRTO's~~ the College's operational plan, fiscal capacity and resource capacity. ~~The~~

Registrar & CEO's annual objectives shall, as required, identify any areas for personal development or focus in the role.

b. Each year, objectives for the Registrar & CEO are considered and, if appropriate, approved by the Executive Committee in accordance with the process as described in paragraph 3.

c. Within 30 days of the beginning of the financial year, the Registrar & CEO prepares draft objectives for that year, for review and comment by the Review Group.

d. The Review Group then meets with the Registrar & CEO to discuss the draft objectives for that year and proposes any changes to the objectives that may be necessary or advisable. -After discussion with the Registrar & CEO, the Review Group and the Registrar & CEO shall determine appropriate revisions to the draft objectives (the draft objectives, as revised, are herein referred to as the "proposed objectives").

e. The Registrar & CEO then presents the proposed objectives to the Executive Committee for its consideration and, if appropriate, approval, with or without revisions. In the event that the Executive Committee proposes revisions to the proposed objectives, after discussion with the Registrar & CEO, the Executive Committee and the Registrar & CEO shall determine appropriate revisions to the proposed objectives which the Executive Committee shall consider for approval (the proposed objectives, as approved by the Executive Committee, are herein referred to as the "approved annual objectives").

f. The approved annual objectives are documented and a copy is retained by the President, on behalf of the Executive Committee, and by the Registrar & CEO.

7. Conducting the Review Process

a. The Review Group is responsible for managing an annual performance review process of the Registrar & CEO, based on the performance expectations described in section 5.

b. The Review Group determines the timing and steps of the Registrar & CEO's performance review process for a particular year.

c. The review process may solicit the input of ~~Council members~~Councillors and staff members.

d. The review process may also solicit input from a wider group of individuals who interact with the Registrar & CEO.

e. The Review Group prepares the survey(s) or other instruments to be used to obtain any input from Council members and other individuals who interact with the Registrar & CEO.

f. The Review Group provides the Registrar & CEO an opportunity to comment on the timing and steps of the review process, any survey(s) or other instruments and, as applicable, the individuals referred to in paragraph d above.

g. The Review Group requests the Registrar & CEO to conduct a self-assessment of the Registrar & CEO's own performance, in the form provided by the Review Group, and to provide additional information as requested or as the Registrar & CEO considers appropriate in support of the Registrar & CEO's self-assessment.

h. The Review Group collates the results from the input received from Council members, if any, and other individuals who were asked to provide input, if any, considers the Registrar & CEO's self-assessment and additional information, and prepares a draft performance review report. The draft performance review report presents any input received from Council members and other persons in such a manner that the identity of any person relative to the input provided by that person cannot reasonably be ascertained.

i. The Review Group may engage a third party to prepare any survey(s) or other instruments, and the form for the Registrar & CEO's self-assessment, to collate the results of the survey(s) or other instruments, and to assist with any other part of the performance review process as the Review Group may determine.

j. At a meeting with the Registrar & CEO, the Review Group reviews the draft performance review report with the Registrar & CEO and finalizes the performance review report. The final performance review report is signed by the President, one other member of the Review Group and the Registrar & CEO. One signed copy is retained by the President, on behalf of the Executive Committee, and one signed copy is retained by the Registrar & CEO.

k. The Review Group reports to the Executive Committee on the completion of the performance review process and its results.

8. No Limitation

This Policy does not preclude the Executive Committee from deciding that other reviews of the Registrar & CEO's performance may be conducted~~, from time to time~~.

9. Timing

The objective is for the Review Group to complete the performance review process by the end of March of each year, if possible, and for the Executive Committee to consider and, if appropriate, approve the annual objectives for the Registrar & CEO for that year by the end of April of each year, if possible. -Keeping in mind these targets, attached as Schedule "A" is a possible timetable for the annual performance review process of the Registrar & CEO.

SCHEDULE "A"

POSSIBLE TIMETABLE FOR ANNUAL PERFORMANCE REVIEW PROCESS

TIMING	Activity
November	Executive Committee determines the composition of the Review Group
December	Council reviews and approves the ~~CMRTO's~~ College's operational plan for the next year
January/ February	Review Group determines the timing and steps for the review process and provides them to the Registrar & CEO for comment. Review Group prepares the survey(s) or other instruments to be used to obtain the input of Council members and others and the form to be used by the Registrar & CEO for the Registrar & CEO's self-assessment. Review Group provides to the Registrar & CEO, for comment, the form of survey(s) or other instruments to be used and the form of self-assessment, and the other individuals who will be asked to provide input regarding the Registrar & CEO's performance Review Group circulates the survey to those persons from whom input regarding the Registrar & CEO's performance is to be sought, and collates feedback Registrar & CEO provides to the Review Group draft annual objectives for the current year, the Registrar & CEO's self-assessment and additional information in support of the Registrar & CEO's self-assessment.
February/ March	Review Group meets to discuss the results of the survey(s) and the Registrar & CEO's self-assessment and additional information and drafts a performance review report. Review Group discusses the draft annual objectives prepared by the Registrar & CEO and proposes revisions, if any. Review Group meets with the Registrar & CEO to discuss: - draft performance review report - draft annual objectives and proposed revisions, if any - final rating of the Registrar & CEO's performance

March/April	At a meeting of the Executive Committee, the Review Group reports that the performance review process is complete and shares the rating. At that meeting, the Registrar & CEO presents the proposed annual objectives for the Registrar & CEO for that year and, if appropriate, the Executive Committee approves the annual objectives with or without amendment.
May/June	Executive Committee reports to Council on the ***completion*** of the performance review process for the Registrar & CEO (but ***not*** on the results of the performance review process unless in an in camera session) and ***approval*** of the annual objectives for the Registrar & CEO as approved by the Executive Committee (but ***not*** on the approved annual objectives themselves unless in an *in camera* session).

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Procedures respecting appeals to Council of decisions of Executive Committee made under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace

Policy 1.7

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy

1. Wherever the Executive Committee is referred to in this Policy, it refers to the Executive Committee in its capacity as the Staff Relations Committee.

2. An appeal of a decision of the Executive Committee made under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace must be made in writing and delivered to the office of the College to the attention of either the President or the Vice-President.

3. An appeal must be received by the President or Vice-President within fifteen (15) days of when the decision was deemed to have been received by the appellant under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace, as the case may be. If an appeal is not received within this time frame, the decision is final and binding on the parties.

4. The President or Vice-President will acknowledge receipt of any appeal properly made in accordance with this Policy (hereinafter referred to as an "Appeal"). The President or Vice-President will promptly inform, in writing, the other parties involved in the complaint made

under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace, as the case may be, of the receipt of any such Appeal, by delivery, if practicable, or by registered mail, if delivery is not practicable. The President or Vice-President will give the appellant and the other parties notice of when Council intends to deal with the Appeal.

5. The appellant and the other parties will be given at least fifteen (15) days to submit written materials to Council in support of or in response to any Appeal.

6. Council may extend or abridge any time prescribed by this Policy on such terms as are just.

7. Council will resolve any Appeal as expeditiously as it can, based on the written materials filed with it. Unless Council specifically permits it, no appellant or other party will be allowed to address Council in support of or in response to any Appeal.

8. Upon its consideration of any Appeal, Council may:

    a. dismiss the Appeal; or,

    b. allow the Appeal, and:

        i. refer the matter back to the Executive Committee for further investigation and decision under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace, as the case may be; or,
        ii. make any decision that the Executive Committee could have made under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace, as the case may be.

9. Any decision made by Council in respect of an Appeal is final and binding on the parties.

10. No decision made by the Executive Committee under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace, as the case may be, is effective until the expiry of the appeal period referred to in section 3, above, or, in the event of an Appeal, until the Appeal is disposed of by Council in the manner referred to in section 8 above. Notwithstanding the foregoing, this does not preclude the Executive Committee from making an interim decision under the Policy and Program regarding workplace harassment or the Policy and Program regarding violence in the workplace, as the case may be, which will be effective until the expiry of the Appeal period, or, in the event of an Appeal, until the Appeal is disposed of by Council.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Procedures respecting approval of accreditation of educational programs

Policy 1.8

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Policy

1. The College receives a copy of the program assessment report ("the Report") and refers it to the next meeting of the Executive Committee. The Executive Committee moves in camera to receive and consider the Report.

2. The Executive Committee reviews the Report and notes any program requirements and proposed future program changes.

3. If the Executive Committee believes that additional information is required, the Executive Committee may request to review all of the documentation gathered by 8872147 Canada Inc., a subsidiary of the Canadian Medical Association, or, as of February 1, 2018, Accreditation Canada, an affiliate of Health Standards Organization (the "Approved Accreditation Body"), with respect to the assessment of the program.

4. If the Executive Committee believes that the Report discloses a problem with the program, the Executive Committee may consider conducting a separate College survey.

5. If the Executive Committee is satisfied with the Report, the Executive Committee moves out of in camera session, determines that it is satisfied with the Report and directs the Registrar & CEO to follow up with the Approved Accreditation Body regarding the program's compliance with respect to any requirements arising from the Report.

6. After the Executive Committee has reviewed the Report, the Executive Committee reports

on its review of the Report, the program's accreditation status, the number of years for which the program has been accredited and any steps the Executive Committee has determined to take to Council in an in camera session.

7. Council moves out of the in camera session and the Executive Committee reports to Council that the program has been accredited pursuant to the Accreditation Services Agreement (the "Agreement") between the Approved Accreditation Body and the College dated February 1, 2000 in the case of the Canadian Medical Association (CMA), which was assigned by the CMA to 8872147 Canada Inc. as of January 1, 2015, or February 1, 2018 in the case of Accreditation Canada, an affiliate of Health Standards Organization. This information is then recorded in the Council minutes.

8. If the name of the educational institution offering the educational program has changed or the name of the educational program in one of the specialties has changed from that listed in O. Reg. 866/93, as amended (the "Registration Regulation"), and the program has been accredited pursuant to the Agreement, Council will consider and, if appropriate, approve the new name of the educational institution and/or the program as equivalent to a program in the relevant specialty listed in the Schedule to the Registration Regulation related to the relevant specialty.

9. If the program in one of the specialties offered by the educational institution is not listed in the Registration Regulation and the program has been accredited pursuant to the Agreement, Council will consider and, if appropriate, approve the program as equivalent to a program in the relevant specialty listed in the Schedule to the Registration Regulation related to the relevant specialty.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Publication of names of suspended members

Policy 1.9

Section:	Administration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Policy

~~That t~~The list of members suspended for failure to pay fees will be published in each issue of the ~~CMRTO's publication, *Insights*~~newsletter of the College.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Registrar & CEO Position Description

Policy 1.10

Section:	Administration		
Approved By:	Council	**Public:**	No
Approved Date:	June 15, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	July 1, 2017	**Last Reviewed:**	
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Policy

The Registrar is the Chief Executive Officer (CEO) of the College and is responsible for and directs the administration of the affairs and operations of the College in accordance with the *Regulated Health Professions Act, 1991* (the RHPA), the *Medical Radiation Technology Act, 1991* (the Act),[1] the regulations made under the RHPA and the Act, and the College's by-laws, policies and guidelines.

The Registrar & CEO is responsible for all aspects of the College's operations. Key areas of responsibility include: regulatory functions; Council liaison and support; policy and program development and implementation; operations planning and management; human resources; financial management; and member and external relations.

Key Responsibilities

1. Regulatory Functions

The Registrar & CEO:

1. performs the regulatory functions of the Registrar under the RHPA, the Act, the regulations made under the RHPA and the Act, and the by-laws including, but not limited to,
    a. maintaining the public register in the form required by the RHPA and the by-laws,

[1] On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiation Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force.

   b. the registration of applicants and annual renewal of members and the related processes,
   c. the handling of complaints and reports regarding the conduct or actions of members and the related processes ~~related thereto~~,
   d. the appointment of investigators and the related processes ~~related thereto~~, and
   e. the election and appointment of members to Council ~~of Council members~~ and the related processes ~~related thereto~~;
2. provides support to, or ensures qualified staff support to, all College committees, including, but not limited to,
   a. Inquiries, Complaints and Reports Committee,
   b. Discipline Committee,
   c. Fitness to Practise Committee,
   d. Patient Relations Committee,
   e. Quality Assurance Committee,
   f. Registration Committee, and
   g. Executive Committee;
3. ensures the orientation of Councillors and committee members with respect to their roles and responsibilities and the legislation and policies governing the Council and College committees;
4. keeps informed of government activities and the activities of other regulatory bodies and advises the Council, as appropriate;
5. apprises the Council of relevant legislative changes affecting the College and the practice of the profession in Ontario;
6. assists Council, as required, with the preparation and delivery of presentations to the government, members, and other groups, on the College and issues which affect the College, its members or the public;
7. implements such forms as the Registrar & CEO considers necessary or advisable to enable the College to fulfill its obligations under the RHPA, the Act, the regulations made under the RHPA and the Act, and the by-laws, and to enable the College to administer its affairs in an appropriate manner; and
8. supports any other requirement arising out of the regulatory role of the College.

2. Council Liaison and Support

The Registrar & CEO shall be ex officio the clerk of the Council and shall:

1. attend all meetings of Council and record all minutes of proceedings in the manner required by the Council;
2. give all notices required to be given to Councillors and members of the College;
3. schedule, on the direction of the President or as otherwise provided in the by-laws, all Council meetings; prepare agendas in consultation with the President, reports and background materials; identify issues requiring Council's attention and recommend courses of action;

4. act in an advisory capacity to the President of the Council;
5. provide support to committees in connection with their regulatory and other functions by, directly or through qualified staff support, preparing agenda and related materials for committee meetings and distributing minutes of committee meetings; and
6. oversee the planning and organization of any special meetings of the College.

3. Policy and Program Development and Implementation

The Registrar & CEO:

1. facilitates the development, implementation and evaluation of the College's programs under the RHPA, the Act, the regulations made under the RHPA and the Act, and the by-laws, under the direction of the Council and its committees, as appropriate;
2. facilitates the development, implementation and evaluation of policies, including but not limited to Council policies, under the direction of the Council and its committees, as appropriate;
3. facilitates the development of official positions, regulatory instruments and documents, including but not limited to regulations, by-laws, standards, guidelines and discussion papers, under the direction of the Council and its committees, as appropriate; and
4. identifies and monitors developments in health care and the profession and coordinates the tracking and analysis of data relevant to the College's mandate.

4. Operations Planning and Management

The Registrar & CEO:

1. assumes responsibility for initiating and maintaining an appropriate organizational planning process in order for the College to achieve the objectives set out in the strategic plan approved by Council;
2. identifies information management needs and implements, maintains and evaluates information systems in accordance with records management policies of Council and any applicable legislation; ensures the integrity and security of the system;
3. acts as a signatory for official documents in accordance with the by-laws and any applicable Council guidelines and policies;
4. arranges for the acquisition and use of resources required for the operations of the College, and negotiates contracts and insurance coverage on behalf of the College; and
5. acts as custodian of the seal of the College and of all books, papers, records, contracts and other documents belonging to the College.

5. Human Resources

The Registrar & CEO:

1. identifies and informs Council of the staffing structure;

2. hires, orients, supervises and dismisses staff as appropriate and determines the terms of employment of all other employees of the College;
3. organizes staff to ensure efficient and effective use of resources to meet operational needs; and
4. creates a positive, safe and functional work environment, including providing performance reviews, coaching of staff and opportunities for development.

6. Financial Management

The Registrar & CEO:

1. prepares the College's annual budget for approval by the Council;
2. administers the implementation of the approved budget in a cost-effective manner;
3. ensures accurate accounting and reporting, including, but not limited to,
    a. keeping a full and accurate account of all financial affairs of the College in proper form,
    b. depositing all moneys and other valuables in the name and to the credit of the College in such depositories as may be designated by the Council,
    c. disbursing the funds of the College under the direction of the Council, and
    d. rendering to the Council, whenever required, an account of all transactions and of the financial position of the College;
4. coordinates and supports the annual audit process; and
5. invests the funds of the College in such manner as the Council may direct.

7. Member and External Relations

The Registrar & CEO:

1. assumes responsibility for disseminating information about the College's mandate and activities to members, the public, organizations, the government, and the media;
2. establishes, maintains and monitors the quality of communications with members, the public and other stakeholders;
3. develops and maintains senior level contacts and working relationships with appropriate government and other agency officials interested in, or responsible for, the regulation of the College and health care and acts as a primary spokesperson with these officials;
4. responds to enquiries from applicants, members, other organizations, government agencies and others;
5. assures the consistency of the College's image in all publications and communications; and
6. speaks for and on behalf of the College with respect to its policies and positions.

8. General

1. The Registrar & CEO carries out any other duties assigned by Council.
2. The Registrar & CEO may, as appropriate in the circumstances, directly or through qualified staff or external support, cause the Registrar & CEO's duties to be carried out.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Deputy Registrar

Policy 1.11

Section:	Administration		
Approved By:	Council	**Public:**	No
Approved Date:	June 15, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	July 01, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Policy

There shall be a Deputy Registrar with such duties as may be determined by the Registrar & CEO of the College.

Background

Through a risk assessment, Council has identified the loss of the senior management team as a high risk for the operations of the College, and specifically the position of Registrar & CEO. Council has also identified the need for an emergency succession plan, should Council need to replace the current Registrar & CEO for reasons such as death, injury or incapacity. The process for appointing an Acting Registrar to carry on the obligations of the College in such a circumstance are set out in Policy 1.12.

The position of the Deputy Registrar has been created for the purposes of emergency succession planning and knowledge transfer. The Registrar & CEO will ensure that the Deputy Registrar is briefed in the current policy issues and is knowledgeable about on-going operations to ensure that the emergency succession plan is implementation ready.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Procedures in the event of the Registrar & CEO's Unplanned Absence

Policy 1.12

Section:	Administration		
Approved By:	Council	**Public:**	No
Approved Date:	June 15, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	July 01, 2017	**Last Reviewed:**	
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Policy

In order to address the risk of the loss of the ability to fulfil the statutory obligations of and the services of the Registrar & CEO of the College during a short term, long term or permanent unplanned absence, the procedures set out below will be followed.

Background

Council recognizes that the continuous performance of executive duties handled by the Registrar & CEO are critical to the College's ability to fulfil its ongoing statutory obligations and manage the College's operations, and that an unplanned absence could affect such obligations and performance. Accordingly, Council has considered it appropriate to create the position of Deputy Registrar and to adopt the following as procedures to be followed in the event of an unplanned absence of the Registrar & CEO.

Definitions

(i) "**unplanned absence**" means an absence of the Registrar & CEO from the position of Registrar & CEO that arises unexpectedly (in contrast to a planned leave, such as a vacation).

(ii) "**Short Term Temporary Absence**" means an unplanned absence of less than three (3) months from which it is expected that the Registrar & CEO will return to the position of Registrar & CEO after the events precipitating the unplanned absence are resolved.

(iii) "**Long Term Temporary Absence**" means an unplanned absence which is expected to last more than three (3) months and from which it is expected that the Registrar & CEO will return to

the position of Registrar & CEO after the events precipitating the unplanned absence are resolved.

(iv) "**Permanent Unplanned Absence**" means an unplanned absence with respect to which it is determined that the Registrar & CEO will not be returning to the position of Registrar & CEO.

Procedures

1. Implementing the procedures: Council, or the Executive Committee on behalf of Council, is authorized to implement these procedures in the event of an unplanned absence.

2. Informing the President: In the event of an unplanned absence, the Deputy Registrar (or in the absence or incapacity of the Deputy Registrar) the highest ranking staff member available shall immediately inform the President of the unplanned absence.

3. Initial meeting of the Executive Committee (or of Council): As soon as reasonably practical after becoming aware of an unplanned absence, the President shall convene a meeting of the Executive Committee (or of Council):

(a) to affirm these procedures;

(b) to make such modifications to these procedures as the Executive Committee (or Council) determines appropriate; and / or

(c) to consider whether the unplanned absence is expected to be a Short Term Temporary Absence, a Long Term Temporary Absence, or a Permanent Unplanned Absence.

4. Subsequent meetings of the Executive Committee (or of Council): At any time during an unplanned absence, the President may convene a meeting of the Executive Committee (or of Council):

(a) to make such modifications to these procedures as the Executive Committee (or Council) determines appropriate; and / or

(b) to consider whether the unplanned absence continues to be expected to be a Short Term Temporary Absence, a Long Term Temporary Absence or a Permanent Unplanned Absence.

5. Communication with the Registrar & CEO during an unplanned absence: Throughout an unplanned absence, the President or designate shall communicate with the Registrar & CEO only as appropriate in the circumstances with a view to being informed (to the extent appropriate in the circumstances) regarding the expected duration of the unplanned absence and with sensitivity to the needs of the Registrar & CEO during such period (including with respect to privacy) while always respecting and abiding by the College's policies and procedures in the context of the Registrar & CEO's employment relationship with the College.

6. Informing the Deputy Registrar of short term Acting Registrar status: At any time during an unplanned absence, if the unplanned absence has most recently been determined to be a Short Term Temporary Absence, the President shall inform the Deputy Registrar that the Deputy Registrar shall be the Acting Registrar during the unplanned absence for a specific time period, such time period not to exceed the shorter of:

(a) the duration of the unplanned absence; and

(b) three (3) months.

7. Informing the Deputy Registrar of long term Acting Registrar status: At any time during an unplanned absence, if the unplanned absence has most recently been determined to be a Long Term Temporary Absence, the President shall inform the Deputy Registrar that the Deputy Registrar shall be the Acting Registrar during the unplanned absence for a specific time period, such time period not to exceed the duration of the unplanned absence.

8. Assistance for the Acting Registrar during a Long Term Temporary Absence: At any time during an unplanned absence, if the unplanned absence has most recently been determined to be a Long Term Temporary Absence, the President shall convene a meeting of the Executive Committee (or of Council) to give consideration, in consultation with the Registrar & CEO if possible, to engaging temporarily an individual to assist the Acting Registrar with any of the duties and responsibilities for which the Acting Registrar is responsible in the capacity as Deputy Registrar and / or Acting Registrar.

9. Completion of an unplanned absence – Registrar & CEO's return: In the event that the Registrar & CEO returns or plans to return from an unplanned absence, the President or designate shall communicate with the Registrar & CEO with a view to facilitating such return, including (as appropriate in the circumstances) a gradual return.

10. Permanent Absence: Council Meeting: At any time during an unplanned absence, if the unplanned absence has most recently been determined to be a Permanent Absence, the President shall convene a meeting of Council to give immediate consideration to plan and to carry out a transition to a new permanent Registrar & CEO.

11. Responsibilities and Authority of Acting Registrar: In the event that the Deputy Registrar is informed that the Deputy Registrar shall be the Acting Registrar, during the relevant time period, the Deputy Registrar as Acting Registrar shall have the same responsibilities as the Registrar & CEO (as set out in Policy 1.10) and the same authority for decision-making and action as the Registrar & CEO.

12. Deputy Registrar's absence or inability to act: In the event of the Deputy Registrar's absence or inability to act as Acting Registrar:

(a) The Executive Committee (or Council) may appoint another employee of the College as Acting Registrar in accordance with these procedures as varied according to the circumstance of the situation; and

(b) the term "Deputy Registrar" in these procedures shall be deemed to refer to such other individual.

13. Compensation: The Deputy Registrar acting as Acting Registrar may be offered a bonus or stipend with respect to acting as Acting Registrar as determined by the Executive Committee (or Council) (such bonus or stipend to be in addition to, and not in replacement of, the compensation to which the Deputy Registrar is otherwise entitled).

14. Monitoring the work of the Acting Registrar: The Executive Committee (or Council) shall be responsible for monitoring the work of the Acting Registrar during the relevant time period(s) and shall be sensitive to the needs of the Acting Registrar during such period(s), while always respecting and abiding by the College's policies and procedures in the context of the Acting Registrar's employment relationship with the College.

15. Communication plan: After the Deputy Registrar has been informed of the appointment as Acting Registrar, the President will communicate to the College's stakeholders the fact of the appointment in accordance with a communication plan prepared by the President or designate.

16. Advice: At any time during an unplanned absence, the Executive Committee (or Council) may engage such professional and / or consulting advice as considered appropriate in the circumstances.

College of Medical Radiation Technologists of Ontario
Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Executive Committee

Policy 2.1

Section:	Governance		
Approved By:	Council	**Public**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	January 1, 2015 March 27, 2018 December 7, 2018	**Next Review Date:**	September 2020

Policy: Terms of Reference for the Executive Committee

Purpose

The Executive Committee of the College provides leadership to Council, and facilitates the effective functioning of Council by providing input to background materials and making policy recommendations.

In support of Council, the Executive Committee shall have responsibility for:

- Leadership regarding governance policies and practices
- Leadership regarding the performance review process of the Registrar & CEO and succession-planning, and staff relations matters as set out below
- Risk identification and oversight
- Crisis management

Responsibilities

1. Acts as the Council between scheduled Council meetings, if necessary[1]

[1] Section 12(1) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991* states: "Between the meetings of the Council, the Executive Committee has all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention, other than the power to make, amend or revoke a regulation or by-law." If the Executive

2. Provides advice to the President on the development of Council agendas as required

3. Monitors, evaluates and reports on the governance structure, policies and processes of Council

4. Develops, implements and evaluates the Council orientation process and Council education to facilitate good governance practices and behaviours

5. Promotes and leads the evaluation processes for Council and statutory committee members to consistently improve governance performance

6. Leads the performance review process of the Registrar & CEO, the negotiation of the Registrar & CEO's compensation, and appropriate succession and contingency planning for the position of Registrar & CEO. This includes a market review of the salary range for the Registrar & CEO position at least every three to five years. It also includes whether to recommend to Council an adjustment to the salary range of the Registrar & CEO

7. Considers whether to recommend to Council an adjustment to the salary ranges of College staff

8. Reviews the College's human resources policies at least once a year

9. Carries out the powers and duties of the Staff Relations Committee as set out in the policies of the College entitled "Policy and Program regarding workplace harassment" and "Policy and Program regarding violence in the workplace"

10. Identifies and monitors areas of risk in College activities and affairs, oversees measures put into place by management to manage those risks, and reports to the Council and recommends policies as required

11. Acts as the Privacy Committee for the purposes of the Privacy Code

12. Reports on its actions to the Council on a timely basis

Meeting Frequency

The Executive Committee shall meet no less than three (3) times per year, at the call of the President. Meetings may be conducted in person or by teleconference.

Composition

The Executive Committee shall include:

- four (4) Professional Councillors
- two (2) Publicly-Appointed Councillors

The President and Vice-President shall be among the members of the Executive Committee.

Committee uses this power, it is required to report on its actions to the Council at the next Council meeting.

The President shall be Chair of the Executive Committee. A majority of the members of the Executive Committee shall constitute a quorum.

The Registrar & CEO shall attends all meetings of the Committee except for personnel matters related to the Registrar & CEO and declared by the President to require in camera deliberation.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Inquiries, Complaints and Reports Committee

Policy 2.2

Section:	Governance		
Approved By:	Council	**Public**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy: Terms of Reference for the Inquiries, Complaints and Reports Committee

Purpose

The Inquiries, Complaints and Reports (ICR) Committee of the College investigates complaints and considers reports regarding the conduct of members and disposes of them in accordance with legislation. The ICR Committee also conducts inquiries related to a member's fitness to practice. The ICR Committee makes independent decisions within its legislated mandate, and prepares reports for Council on its activities.

Responsibilities

1. Investigates complaints and considers reports on investigations, relevant documentation, health records and members' responses
2. Decides how to dispose of the complaint or report and prepares reasons for decisions
3. Delivers oral cautions to members
4. Makes inquiries into a member's fitness to practise
5. Reviews decisions of the Health Professions Appeal and Review Board and takes appropriate action
6. Evaluates and measures performance against any College plan or policy

7. Makes recommendations and provides advice on any discrepancies or areas that need improvement

8. Brings forward to Council any matter that the Committee deems relevant within its mandate

Meeting Frequency

Approximately six meetings per year, with one day of preparation time per meeting.

Composition

- At least two (2) Professional Councillors
- At least two (2) Publicly-Appointed Councillors
- At least four (4) Non-Council Committee Members

The Chair shall be appointed by the Council.

Generally, the Committee functions in two separate panels: one for matters relating to complaints and reports, and another for matters relating to inquiries into a member's fitness to practise.

Each panel must be composed of at least three persons: at least one each of a Professional Councillor, a Publicly-Appointed Councillor and a Non-Council Committee Member.

A majority of the members of a Committee and a panel shall constitute a quorum.

The Committee and the panels are supported by the Director of Professional Conduct.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Discipline Committee

Policy 2.3

Section:	Governance		
Approved By:	Council	**Public**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy: Terms of Reference for the Discipline Committee

Purpose

A panel of the Discipline Committee of the College adjudicates specified allegations of professional misconduct and/or incompetence referred to it by the Inquiries, Complaints and Reports (ICR) Committee. The Discipline Committee makes independent decisions within its legislated mandate, and prepares reports for Council on its activities.

Responsibilities

1. At a hearing, panel members:
    a. consider the allegations set out in the Notice of Hearing, hear evidence and ascertain the facts of the case
    b. determine whether the allegation has been proved and the member has committed an act of professional misconduct or is incompetent
    c. determine the penalty to be imposed, in the case of a finding
2. Evaluates and measures performance against any College plan or policy
3. Makes recommendations and provides advice on any discrepancies or areas that need improvement
4. Brings forward to Council any matter that the Committee deems relevant within its mandate

Meeting Frequency

The meeting frequency is variable, depending on the composition of the panels, and the number, complexity, and length of the hearings.

The Committee meets at least once a year for orientation and training.

Composition

- At least two (2) Professional Councillors
- At least two (2) Publicly-Appointed Councillors
- At least four (4) Non-Council Committee Members

The Chair shall be appointed by the Council. Panel members for each hearing are selected by the Chair from the Discipline Committee members.

Each panel must be composed of at least three and no more than five persons: at least one Professional Councillor and two Publicly-Appointed Councillors. Three members of a panel, at least one of whom must be a Publicly-Appointed Councillor, shall constitute a quorum.

The Committee and the panels are supported by the Director of Professional Conduct.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Fitness to Practise Committee

Policy 2.4

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy: Terms of Reference for the Fitness to Practise Committee

Purpose

A panel of the Fitness to Practise Committee of the College adjudicates allegations of incapacity referred by the Inquiries, Complaints and Reports (ICR) Committee in order to determine if a member is incapacitated. The Committee makes independent decisions within its legislated mandate, and prepares reports for Council on its activities.

Responsibilities

1. At a hearing:
    a. panel members consider evidence from the College and from the member
    b. after determining the facts, the Committee makes a finding on whether or not the member is incapacitated and then makes an appropriate order

2. Evaluates and measures performance against any College plan or policy

3. Makes recommendations and provides advice on any discrepancies or areas that need improvement

4. Brings forward to Council any matter that the Committee deems relevant within its mandate

Meeting Frequency

The meeting frequency is variable, depending on the composition of the panels, and the number, complexity and length of the hearings.

The Committee meets at least once a year for orientation and training.

Composition

- At least one (1) Professional Councillor
- At least one (1) Publicly-Appointed Councillor
- At least two (2) Non-Council Committee Members

The Chair shall be appointed by the Council. Panel members for each hearing are selected by the Chair from the Fitness to Practise Committee members.

Each panel must be composed of at least three persons: at least one each of a Professional Councillor, a Publicly-Appointed Councillor and a Non-Council Committee Member.

A majority of the members of the Committee and a panel shall constitute a quorum.

The Committee and the panels are supported by the Director of Professional Conduct.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Patient Relations Committee

Policy 2.5

Section:	Governance		
Approved By:	Council	**Public**	Yes
Approved Date:	March 29, 2014	**Review Schedule:**	Every 3 years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Policy: Terms of Reference for the Patient Relations Committee

Purpose

The Patient Relations Committee of the College advises Council on the patient relations program[1], and other matters related to enhancing the relationship between the public and members. The Committee also administers the College's program for funding therapy and counseling for eligible persons in accordance with legislation ~~who were sexually abused by a member (eligibility requirements are set out in the legislation)~~.[2]

The Committee reports directly to Council, and prepares formal reports to Council on its activities.

Responsibilities

1. Develops policies and guidelines related to administering ~~the~~ funding for therapy ~~or~~ and counseling for eligible persons~~for patients who have been sexually abused by members~~

2. Reviews and considers applications for funding for therapy and counselling

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[1] The Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991* (the Code) requires the patient relations program to include measures for preventing and dealing with sexual abuse of patients. Section 84(3) provides that the measures must include "…educational requirements for members; guidelines for the conduct of members with their patients; training for the College's staff; and the provision of information to the public."

[2] The eligibility requirements for funding for therapy and counselling in connection with allegations of sexual abuse by members are set out in the Code.

3. Evaluates and measures performance against any College plan or policy

4. Makes recommendations and provides advice on any discrepancies or areas that need improvement

5. Brings forward to the Council any matter that the Committee deems relevant within its mandate

Meeting Frequency

The meeting frequency is variable, depending on whether there are any applications for funding for therapy ~~or~~ and counseling from ~~patients who have been sexually abused by members~~eligible persons.

The Committee meets at least once per year to review the educational materials related to the College's sexual abuse prevention program.

Composition

The Patient Relations Committee shall be composed of the members of the Executive Committee.

The Chair shall be appointed by the Council. A majority of the members of the Committee shall constitute a quorum.

The Committee is supported by the Director of Professional Conduct.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Quality Assurance Committee

Policy 2.6

Section:	Governance		
Approved By:	Council	**Public**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Policy: Terms of Reference for the Quality Assurance Committee

Purpose

The Quality Assurance Committee of the College develops and administers a quality assurance program that includes:

1. Continuing education or professional development designed to:
    a. Promote continuing competence and continuing quality improvement among members,
    b. Address changes in practice environments, and
    c. Incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues in the discretion of the Council
2. Self, peer and practice assessments
3. A mechanism to monitor members' participation in, and compliance with, the program
4. The collection, analysis and dissemination of information.

The Committee reports directly to Council, and prepares reports on its activities to Council.

Responsibilities

1. Assesses whether members have met the requirements of the quality assurance program

2. Discusses the implementation of the College's comprehensive continuing competency/quality improvement program

3. Evaluates and measures performance against any College plan or policy

4. Makes recommendations and provides advice on any discrepancies or areas that need improvement

5. Brings forward to Council any matter that the Committee deems relevant within its mandate

Meeting Frequency

The Committee meets approximately eight times per year.

Composition

- At least one (1) Professional Councillor
- At least one (1) Publicly-Appointed Councillor
- At least three (3) Non-Council Committee Members

The Chair shall be appointed by the Council.

The Committee may sit as a panel for the assessment of members' QA records. Each panel must be composed of at least three persons: at least one each of a Professional Councillor, a Publicly-Appointed Councillor and a Non-Council Committee Member.

A majority of the members of the Committee and a panel shall constitute a quorum.

The Committee and the panels are supported by the Director of Quality Assurance.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Registration Committee

Policy 2.7

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Policy: Terms of Reference for the Registration Committee

Purpose

The Registration Committee of the College assesses applications for registration which have been referred to the Committee by the Registrar to determine whether the applicants meet the requirements for registration to practise the profession in Ontario, in a fair, transparent, objective and impartial manner.

The Committee makes independent decisions regarding applications for registration, and prepares reports for Council on its activities.

Responsibilities

1. Assesses whether an applicant is eligible for registration in Ontario in accordance with the provisions of the registration regulation and determine if any terms, conditions, or limitations should be imposed on the certificate of registration

2. Determines whether to direct the Registrar to issue a certificate of registration for an applicant and prepare reasons for the decision

3. Monitors that all fair registration practices reports, audits and other reports as required are submitted to the Office of the Fairness Commissioner to demonstrate that the registration practices of the College meet the legislated requirements and the duty to provide registration practices that are transparent, objective, impartial and fair

4. Reviews research and holds conceptual/policy discussions to develop policies to support registration practices

5. Evaluates and measures performance against any College plan or policy

6. Makes recommendations and provides advice on any discrepancies or areas that need improvement

7. Brings forward to Council any matter that the Committee deems relevant within its mandate

Meeting Frequency

The Committee meets approximately nine times per year.

Composition

- At least one (1) Professional Councillor
- At least one (1) Publicly-Appointed Councillor
- At least three (3) Non-Council Committee Members

The Chair shall be appointed by the Council. ~~Previous experience with the approved educational programs is an asset, but not a requirement.~~

Generally, the Committee functions as a panel for matters relating to assessing applications for registration.

Each panel must be composed of at least three persons: at least one each of a Professional Councillor, a Publicly-Appointed Councillor and a Non-Council Committee Member. A majority of the members of a Committee and a panel shall constitute a quorum.

The Committee and the panels are supported by the Deputy Registrar.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Terms of Reference for the Finance and Audit Committee

Policy 2.8

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	September 26, 2017	**Next Review Date:**	September 2020

Policy: Terms of Reference for the Finance and Audit Committee

Purpose

The role of the Finance and Audit Committee of the College is to assist the Council in meeting its financial responsibilities. The Committee shall provide guidance to Council on financial matters as required.

Responsibilities:

It is the responsibility of the Finance and Audit Committee to consider and make recommendations to the Council on the following matters:

Policies

1. Major policies governing financial, budgetary and investment matters
2. The accounting policies to be followed in the preparation of annual financial statements
3. Policies relating to discretionary expenditures, travel and expense accounts, credit cards and other benefits, including the use of corporate assets

Resource Planning

4. The three-year financial projection and annual budget
5. The appropriate level of unrestricted net assets balance to be maintained at year end

6. The annual fee to be paid by members, and other fees set out in the College's by-laws as the Council directs

7. The long-term commitments to be assumed

Financial Performance Monitoring

8. The results of quarterly financial performance relative to approved annual budget

Financial Reporting and Audit

9. The adequacy of a system of internal controls established by management to support financial risk management

10. The quality of annual financial statements relative to approved Council policies

11. The quality of an audit plan developed by the external auditors, the results of the audit contained in the opinion, and response to any items identified in the audit management letter

12. The nature and quality of any financial information provided to external stakeholders

Investments

13. The investment strategy to be adopted, at a minimum of every three years, or as directed by Council

14. The quality of investment proposal(s) from financial advisors on the investment of surplus funds in accordance with established investment policies

15. The quarterly and annual performance of the investment portfolio in the context of approved investment strategy and policies

Other

16. Any other responsibilities as determined by the Council

Meeting Frequency

The Committee meets approximately four times per year.

Composition

A minimum of four (4) Councillors shall serve on the Finance and Audit Committee including at least one (1) Publicly-Appointed Councillor. Other persons may be appointed to the Committee. The majority of members may be Executive Committee members. Council will appoint the Chair of the Committee and that person shall not be the President of the Council.

A majority of the members of the Finance and Audit Committee shall constitute a quorum.

The Registrar & CEO shall attend all meetings of the Committee except for meetings or portions thereof dealing with matters with respect to which the Registrar & CEO has a conflict of interest.

College of Medical Radiation Technologists of Ontario

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Terms of Reference for the Nominating Committee

Policy 2.9

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Policy: Terms of Reference for the Nominating Committee

Purpose

The role of the Nominating Committee of the College is to review applicants and make recommendations for committee membership. The list of applicants should be forwarded to the Executive Committee prior to the June Council meeting. The Nominating Committee is also responsible for reviewing expressions of interest for the position of the Academic Councillor in accordance with Council Policy.

Responsibilities

Each year the Nominating Committee shall:

1. Request that each Councillor submit a Committee and Committee Chair preference sheet

2. Set a date, which is prior to the first Council meeting following the election of Councillors, by which Councillors may submit nominations for the office of President and Vice-President to the Nominating Committee and communicate such date to Councillors

3. Accept nominations for election of President and Vice-President on or before the date set by the Nominating Committee for receipt of nominations for the office of President and Vice-President

4. Review the nomination process for the election of President and Vice-President and the appointment of Non-Council Committee Members and chairs of the statutory committees and other committees with the Executive Committee prior to the first Council meeting following the election of Councillors

5. Present the proposed nomination slate to Council at the first Council meeting following the election of

Additional nominations shall be accepted at the first Council meeting following the election of Councillors, except for nominations for the office of President and Vice-President which shall only be accepted on or before the date set by the Nominating Committee as referred to above.

Meeting Frequency

The Nominating Committee shall meet at least once per year.

Composition

Four (4) Councillors shall serve on the Nominating Committee, including one Publicly-Appointed Councillor. The Council shall appoint the Chair.

A majority of the members of the Nominating Committee shall constitute a quorum.

The Registrar & CEO shall attend all meetings of the Nominating Committee.

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Terms of Reference for the Staff Relations Committee

Policy 2.10

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	January 1, 2015	**Next Review Date:**	September 2020

Policy: Terms of Reference for Staff Relations Committee

Purpose

The Executive Committee of the College shall act in the capacity of a Staff Relations Committee. The Staff Relations Committee shall meet at least once per year to review the report of the staff liaison representative and appoint a staff liaison representative for the following year.

The powers and duties of the Executive Committee, acting in its capacity as Staff Relations Committee, shall include all of the powers and duties of the Staff Relations Committee set out in the policy entitled "Policy and Program regarding workplace harassment" and "Policy and Program regarding violence in the workplace".

Composition

The President shall be the Chair of the Staff Relations Committee. A majority of the members of the Committee shall constitute a quorum.

The Registrar & CEO shall attend all meetings of the Committee except for personnel matters related to the Registrar & CEO and declared by the Chair to require in camera deliberation.

College of Medical Radiation Technologists of Ontario
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Roles and Responsibilities of the Council

Policy 2.11

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 28, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	June 19, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Policy

The Council of the College acts as the board of directors of the College and is responsible for managing and administering its affairs.[1] The Council is responsible for regulating the profession in the public interest. It achieves this through policy-making, goal and priority setting, planning, decision-making and oversight.

In carrying out its role, the Council shall:

1. Fulfill the legislated responsibilities set out in the *Regulated Health Professions Act, 1991*, including the Health Professions Procedural Code, the *Medical Radiation Technology Act, 1991*[2] (the Act) and the regulations made under those Acts, to ensure that all the statutory responsibilities of the College, its statutory committees and its employees are met[3]

2. Establish and review the College's regulations and by-laws

3. Establish and review policies, position statements, and guidelines in accordance with relevant legislation

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[1] Section 4 of the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*.
[2] On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiation Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force.
[3] The statutory duties and objects of the College set out in legislation are attached to this policy as Appendix 1.

4. Maintain the financial integrity of College

5. Consider and recommend any changes to legislation necessary for the College to meet its mandate

6. Establish and review the standards of practice for the profession and other policies relevant to protecting the public interest

7. Establish and promote the College's mission, vision and values

8. Develop, approve and regularly revise the strategic plan of the College consistent with its statutory obligations and the mission, vision and values

9. Oversee the evaluation of the College's activities and assess the College's achievement of its strategic plan

10. Allocate resources by setting broad budget priorities based on the strategic plan, approve budgets based on these priorities, and monitor financial performance

11. Monitor and evaluate the governance framework of the College regarding committees, financial management, risk management and reporting to ensure compliance with requirements and to monitor performance

12. Receive reports from all statutory committees, non-statutory committees and task forces

13. Review and monitor its own effectiveness as a governing body

Composition

The Council shall be composed in the manner set out in the by-laws of the College.~~is comprised of:~~

~~Eight (8) Councillors who are members of the CMRTO (elected members)~~

~~Between five (5) and seven (7) Councillors appointed by the Lieutenant Governor in Council (public members)~~

The President and Vice-President are elected annually from ~~the elected members of Council~~among the Councillors. A majority of the Councillors, at least three of whom are Professional Councillors and at least one of whom is a Publicly-Appointed Councillor, shall constitute a quorum.

The Registrar & CEO shall attend all meetings of Council except for personnel matters related to the Registrar & CEO and declared by the President to require in camera deliberation.

Appendix 1

Review of duty and objects of the College

Below are some excerpts from the Health Professions Procedural Code, made under the *Regulated Health Professions Act, 1991*, setting out the statutory duty and objects of the College and provisions regarding Council meetings.

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of College

3. (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their

members.

5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
9. To promote inter-professional collaboration with other health profession colleges.
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

Council

4. The College shall have a Council that shall be its board of directors and that shall manage and administer its affairs. 1991, c. 18, Sched. 2, s. 4.

Quorum

6. A majority of the members of the Council constitute a quorum. 1991, c. 18, Sched. 2, s. 6.

Meetings

7. (1) The meetings of the Council shall be open to the public and reasonable notice shall be given to the members of the College, to the Minister, and to the public. 2007, c. 10, Sched. M, s. 20 (1).

Exclusion of public

(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(a) matters involving public security may be disclosed;

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;

(d) personnel matters or property acquisitions will be discussed;

(e) instructions will be given to or opinions received from the solicitors for the College; or

(f) the Council will deliberate whether to exclude the public from a meeting or whether to make an order under subsection (3). 1991, c. 18, Sched. 2, s. 7 (2); 2007, c. 10, Sched. M, s. 20 (2).

College of Medical Radiation Technologists of Ontario

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Code of Conduct for Councillors and Non-Council Committee Members

Policy 2.12

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 23, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	September 23, 2014	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

In carrying out its objects,[1] the College has a duty to serve and protect the public interest. Council and its committees are committed to ensuring that, in all aspects of its affairs, the College maintains public trust by acting honestly and with integrity and in accordance with its mandate.

Application

This policy applies to Councillors and Non-Council Committee Members. In this policy, Councillors and Non-Council Committee Members are together referred to as "members" and individually as a "member".

Duties

All Councillors have a fiduciary responsibility to the College as a result of being members of the College's board of directors and are bound by the obligations that arise out of their fiduciary duties. All Councillors shall act in the best interests of the College and of the public and shall not act in any way in the interests of any group or segment of the College or the public if such interests are not in the best interests of the College or the public as a whole.

All members shall act with honesty and integrity and shall be loyal to the College. A member shall not put self or personal interests ahead of their statutory responsibilities or the interests of the College.

[1] The College's objects are set out in section 3 of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*.

Every member shall act in the best interests of the public receiving services from medical radiation and imaging technologists in Ontario. No member by reason of their election or appointment shall conduct themself as a representative of any professional, socioeconomic, cultural, or geographic group or other constituency.

Members shall comply with all laws applicable to the College, including, without limitation, the *Regulated Health Professions Act, 1991* (the RHPA), the *Medical Radiation Technology Act, 1991* (the Act),[2] the regulations made under either of those Acts and the College's by-laws. Members shall also at all times adhere to and respect the policies of the College and shall not engage in conduct or actions which are detrimental to the College or contrary to any of its policies.

Confidentiality

Every member must adhere to the provision regarding confidentiality set out in the RHPA which states that every member of a Council or committee of a College shall keep confidential all information that comes to their knowledge in the course of their duties and shall not communicate any information to any other person, except in certain limited circumstances.[3] Every member is required to sign a confidentiality agreement in the form approved by the College's Council at the commencement of the member's term of office, and thereafter when there are any changes to the form of confidentiality agreement.

Spokespersons

The President is the official spokesperson for the Council. It is the role of the President to represent the voice of the Council to all stakeholders.

The Registrar & CEO is the official spokesperson for the College. It is the role of the Registrar & CEO to represent the voice of the College to all stakeholders.

No member shall speak or make representations on behalf of the Council, the College or its committees unless authorized by the President (or, in the President's absence, the Vice-President) and the Registrar & CEO or by the Council. When so authorized, the member's representations must be consistent with accepted positions and policies of the College.

Media Contact and Public Discussion

News media contact and statements and public discussion of the College's affairs should only be made through one of the official spokespersons or other spokesperson authorized in the manner described above. Any member who is questioned by news reporters or other media representatives should refer such individuals to the Registrar & CEO.

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[2] On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiaiton Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force.

[3] Section 36(1) of the *Regulated Health Professions Act, 1991*.

Personal Conduct

All members must conduct themselves in a professional, respectful and courteous manner when conducting College business. Members must not engage in verbal, physical or sexual harassment.

No member shall attempt to influence another member or College staff with regard to the handling or outcome of a matter with respect to which the member has no direct involvement.

Members shall approach every issue with an open mind and impartially, and without discrimination or favouritism. Members shall foster a collegial work environment and conduct themselves in a manner that demonstrates respect for the views and opinions of colleagues.

It is recognized that members have diverse backgrounds, skills and experience. Members will not always agree with one another on all issues. All debates shall be conducted in a respectful and civil manner.

The authority of the President of Council and the chairs of the committees must be respected by all members.

Council and Committee Unity

Members acknowledge that all Council and committee actions and decisions must be supported by all members. The Council and committees speak with one voice. Those members who have abstained or voted against a motion must adhere to and support the decision of the Council or committee.[4]

Meeting Conduct

Each member agrees to:

1. Attend the meetings, workshops or educational sessions of Council and/or the committees to which they are appointed, and be punctual

2. Notify the Registrar & CEO or staff support person in a timely fashion, in writing or otherwise, if the member is unable to attend a Council or committee meeting and provide a reason for the absence

3. Prepare for each meeting by reading the agenda material prior to the meeting

4. State their position and perspective on issues in a clear and respectful manner

5. Engage constructively in the discussions

[4] There may be circumstances where it is appropriate for a Councillor or Non-Council Committee member who disagrees with the majority decision to write a dissent.

6. Where the views of the member differ from that of the majority, engage collaboratively to determine whether a consensus can be reached

7. Pay full attention to the meeting business – avoiding side-bar conversations, taking of phone calls, checking of email on mobile devices, reading of unrelated material, etc.

8. Refrain from speaking when others are speaking and wait to be recognized by the Chair before speaking

9. Be respectful of others

10. Be respectful of the authority of the President or Chair of the committee

11. Respect the boundaries between members and College staff, recognizing that College staff do not work for, or report to, individual members

12. Participate fully in any evaluation processes or continuous quality improvement processes

Acknowledgement

Each member must adhere to this Code of Conduct and commit to support the College's standards set out in applicable legislation, policies and guidelines.

Each member will review and affirm their commitment to and compliance with the College's Code of Conduct at the commencement of the member's term of office, and thereafter when there are any changes to this Code of Conduct.

ACKNOWLEDGEMENT AND AGREEMENT

TO: COLLEGE OF MEDICAL RADIATION TECHNOLOGISTS OF ONTARIO ("CMRTO")

I acknowledge, as a Councillor or a Non-Council Committee Member or both, that I have read and understand the Code of Conduct of the College and agree to conduct myself in accordance with the Code of Conduct.

_____
Signature of member

_____
Print name of member

_____
Date

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Conflict of Interest for Councillors and Non-Council Committee Members

Policy 2.13

Section:	Governance		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 23, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	September 23, 2014	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Purpose

The purpose of this Policy, together with the conflict of interest provisions set out in the ~~general~~ by-laws of the College, is to define circumstances in which a conflict of interest may exist or appear to exist and to set out the responsibilities of Councillors and Non-Council Committee Members with respect to such conflicts. Compliance by Councillors and Non-Council Committee Members with a policy regarding conflict of interest supports the integrity of the decision-making processes of the Council and its committees.

Application

This Policy applies to Councillors and Non-Council Committee Members. In this Policy, Councillors and Non-Council Committee Members are together referred to as "members" and individually as a "member".

Policy

A "conflict of interest" is a situation in which a member has a direct or indirect private or personal interest sufficient, on a reasonable basis, to influence or appear to influence the exercise of their duties.

This includes, but is not limited to, situations involving:

a. a direct or indirect financial interest of the member;
b. organizations to which a member or a member of their immediate family has a direct or indirect obligation; or

c. a professional or personal relationship.

Actual influence is not required in order for a conflict of interest situation to exist. It is sufficient if there is a reasonable apprehension that there may be such influence.

A member should avoid situations in which they have a conflict of interest. Where it is not possible to avoid a situation in which they have a conflict of interest, a member must follow the procedure set out below for handling the conflict of interest situation.

The following are specific examples of circumstances under which a member has a conflict of interest:[1]

1. A member takes advantage of information obtained in connection with their duties as a Councillor or a Non-Council Committee Member for personal gain or benefit;

2. A member or a member of their immediate family holds a position in another organization (such as a director, owner, board member, officer or employee) which involves duties that influence or appear to influence the member's exercise of their duties to the College; and

3. There is a reasonable apprehension of bias.[2]

Procedure

A member who has a conflict of interest in a matter before the Council, a committee, or a panel of a committee, other than a specific matter which involves a member of the College or a former member of the College and which comes before a panel of the Discipline Committee or Fitness to Practise Committee, shall:

1. declare their conflict to the President, Registrar & CEO, Registrar & CEO's designate, or chair of the committee or panel at the time the member identifies the conflict;

2. declare their conflict at the meeting of the Council or meeting of the committee or panel prior to any discussion to which the conflict relates;

3. withdraw from the meeting of the Council or meeting of the committee or panel during any discussion to which the conflict relates;

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[1] These specific examples of circumstances under which a member has a conflict of interest do not limit the generality of the definition of "conflict of interest" set out above.

[2] There may be a reasonable apprehension of bias where a reasonable right minded person, informed of the facts concerning the member is more likely than not to conclude that the member, whether consciously or unconsciously, would not decide fairly. The apprehension of bias must be a reasonable one, held by reasonable and right minded persons, applying themselves to the question and obtaining thereon the required information. In the words of the Court of Appeal, that test is "what would an informed person, viewing the matter realistically and practically -- and having thought the matter through -- conclude. Would he think that it is more likely than not that [the member], whether consciously or unconsciously, would not decide fairly."

4. not vote upon any resolution to which the conflict relates; and

5. not attempt directly or indirectly to influence any decision of the Council or committee or panel or any person fulfilling duties to the College, to which the conflict relates.

A member who has a conflict of interest in a specific matter which involves a member of the College or a ~~past~~ former member of the College and which comes before a panel of the Discipline Committee or Fitness to Practise Committee, shall, prior to the selection of the panel, declare their conflict to the chair of the committee and disqualify themself from participating as a member of the panel in respect of that specific matter. If the member identifies the conflict of interest after a hearing has commenced, the conflict shall be disclosed to the parties and the procedures normally followed at a hearing for deciding whether or not a judge shall recuse themself from a hearing, shall be followed.

If a member believes that another member has a conflict of interest, the member may bring such concern to the attention of the President, the Registrar & CEO or chair of the relevant committee. The President, the Registrar & CEO or committee chair, as the case may be, shall determine the appropriate action to take, if any.

Exceptions

Notwithstanding the foregoing, a member of the Council may attend a meeting of the Council and vote upon a resolution to approve a contract or transaction if:

a. the contract or transaction is one relating primarily to the Councillor's remuneration as a member of the Council; or
b. the contract or transaction is one for indemnity or insurance under ~~Clause 42 of By-law No. 13~~the by-laws of the ~~CMRTO~~College.

~~Amendment of Policy~~

~~This Policy may not be amended unless any relevant corresponding amendments are made to Clause 10 of By-law No. 13.~~

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Risk Management — Policy 2.14

Section:	Governance		
Approved By:	Council	**Public:**	No
Approved Date:	September 23, 2016	**Review Schedule:**	Every 3 Years
Effective Date:	September 23, 2016	**Last Reviewed:**	
Amended Date(s):	December 7, 2018	**Next Review Date:**	September ~~2019~~2020

Purpose

This policy sets out Council's risk management expectations. Through this policy, the Council of the College acknowledges its commitment to create a robust risk management framework. The purpose of the policy is to establish a risk management and oversight system that enables the Council to:

- Be informed of significant risks
- Assess how ~~the~~existing and anticipated ~~-~~risks may affect the College
- Understand and evaluate the inter-relationship of these risks
- Ensure these risks are mitigated and~~-~~/~~-~~or managed

Policy

1. The College shall have a risk management framework in accordance with governance best practices. The risk management framework shall include:
    a. procedures, processes and systems to identify, assess, measure, manage and report on existing and anticipated risks, and
    b. a defined reporting process to enable Council to discharge its risk oversight responsibilities.

2. Consideration of risk shall be an integral part of all College decision-making and management processes including in the development of strategic and annual operational plans.

3. ~~Every three years, t~~This ~~risk management~~ policy and the College's risk management framework shall be assessed in accordance with the review schedule set by Council to ~~validate~~ ensure its continued relevance ~~to~~ in light of emerging political, regulatory, social, economic, technological and other issues, as well as~~and~~ ~~CMRTO's~~ organizational

changes and developments.

4. While t~~T~~he Council is ultimately responsible for risk management oversight, Council ~~but~~ shall delegate ~~the~~ ongoing oversight to the Executive Committee. The Executive Committee shall:
    a. oversee the establishment of procedures, processes and systems to enable the College to identify and manage existing and anticipated risks,
    b. on specific issues, provide the Council with accurate, timely and consistent risk management information to aid corporate governance~~,~~ and enable ~~the~~ Council to discharge its risk management oversight responsibilities, and
    c. provide ~~the~~ Council with an annual report on the functioning of the established risk management framework.

5. Statutory and non-statutory committees shall follow the guidelines of the risk management framework to identify, assess and measure risks arising in the course of their work.

6. ~~CMRTO management~~The Registrar & CEO shall be responsible for maintaining a comprehensive risk register to aid the Executive Committee in discharging its responsibilities to the Council. ~~The management~~ Registrar & CEO may, as appropriate, establish any other risk registers specifically to manage and monitor risk associated with special projects.

7. The Executive Committee shall report to Council on its risk management activities as required.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Faculty member for purposes of the appointment of the Academic Councillor

Policy 3.1

Section:	Election and Appointment		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	December 7, 2018	**Next Review Date:**	March 2021

Policy

A member of the College whose status is designated by the Program Director of a program in ~~medical radiation technology~~the profession to be a member of that faculty is determined to be a member of the College eligible to be appointed as the Academic Councillor in accordance with the by-laws of the College~~vote in the faculty district~~.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Election procedure for the election of the President and Vice-President

Policy 3.2

Section:	Election and Appointment		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018 December 7, 2018	**Next Review Date:**	March 2021

Policy

The following is a summary of the election procedure to be followed at the first meeting of Council after each election of Councillors for the purpose of electing the President and Vice-President in accordance with the by-laws of the College and ~~Wainberg's Society Meetings~~Bourinot's Rules of Order, as applicable.

For the purpose of this policy, "members of Council" means the Councillors elected or appointed in accordance with the by-laws of the College ("Professional Councillors") and members of the Council appointed by the Lieutenant Governor in Council ("Publicly-Appointed Councillors"), and "a member of Council" means any one of the members of Council.

Background

1. The President and Vice-President shall be elected annually by the Council from among the members of Council at the first meeting of Council after each election of Councillors.

2. All nominations for the office of President and Vice-President must be received by the Nominating Committee on or before a date to be set by the Nominating Committee. No other nominations will be accepted.

Election Procedure

1. The election will be conducted by a member of Council (excluding any nominee for the office of President or Vice-President) or other person appointed by Council or the Executive Committee for such purpose. The person so appointed will chair that portion of the Council meeting relating to the election of the President and Vice-President. In the balance of this policy, the person so appointed is referred to as the "Chair".

2. The election of the President is conducted and completed first. Then the election of the Vice-President is conducted and completed.

3. The Chair will announce that the meeting is open for the election of the named office and will advise Council of the name(s) of each candidate(s) who has been duly nominated for the office.

4. If only one nomination is received for the named office, the candidate so nominated will be declared elected by acclamation.

5. If more than one nomination is received for the named office, a vote by secret ballot will take place.

6. College staff will prepare the ballots which will list each of the candidates for the named office.

7. Prior to the vote, the Chair will request a motion to appoint scrutineers.

8. Each nominee will be given an opportunity to speak to Council for three (3) minutes. The scrutineers will then distribute the ballots for that office. The Chair will instruct the members of Council present at the meeting to mark an "X" opposite the name of the person of their choice. The scrutineers will collect the ballots, count them and report back to the Chair by written report.

9. Once the scrutineers have counted the ballots and reported back to the Chair, the Chair will bring the meeting back to order. Unless the Chair disagrees on the validity of a ballot or the count, the Chair will adopt the report of the scrutineers.

10. If one nominee receives more than 50% of the votes cast on the first ballot, the Chair will declare that nominee duly elected for the office for which the election was being held.

11. If no one nominee receives more than 50% of the votes cast on the first ballot, the Chair will declare that the nominee who received the lowest number of votes will be deleted from nomination and a fresh vote will be taken. This procedure is followed until one nominee receives the majority of the votes cast on the ballot. The Chair will then declare the successful nominee duly elected for the named position.

12. If there is a tie vote, the Chair will break the tie by lot.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Significant Accounting Policies

Policy 4.1

Section :	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 1, 2015	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

The purpose of disclosing significant accounting policies used in the preparation of the financial statements of the College is to convey to a user of the financial statements the policies that were followed within the permitted choices of Canadian generally accepted accounting standards.

Policy

1. Management shall prepare the annual financial statements in accordance with the Canadian accounting standards for not-for-profit organizations.

2. Capital assets shall be recorded at cost. These capital assets shall be amortized over their useful lives from the date of acquisition on a straight line basis as follows:
   a. Furniture and equipment – ten years
   b. Computer software – five years
   c. Computer hardware – three years

3. Items of a capital nature that individually cost less than $1,000.00 shall be expensed.

4. Investments shall be stated at market value. The change in the difference between the market value and the cost of investments at the beginning and end of each year shall be reflected in the Statement of Operations.

5. Fixed income securities shall be valued at year-end quoted market prices where available. Where quoted prices are not available, estimated market values shall be calculated using comparable securities. Transaction costs shall be expensed as incurred.

6. Membership and registration fees shall be recognized as revenue in the fiscal year to which they relate.

7. Fees paid in advance shall not be considered as earned and shall be recorded as deferred revenue.

8. External contributions received for specified purposes shall be recognized as revenue in the year in which the related expenses are incurred.

9. Deferred lease inducements shall be amortized on a straight-line basis over the term of the lease.

10. Pension contributions to defined benefit pension plans relating to College employees shall be expensed when such contributions are made.

11. Cash and cash equivalents shall be measured at market value.

12. Uncollectible accounts receivable shall be charged against revenues earned.

13. The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year.

14. This policy shall be examined periodically to account for changes made to Canadian accounting standards, from time to time.

College of Medical Radiation Technologists of Ontario
Ordre des technologues en radiation médicale de l'Ontario

Financial Plan, Annual Budget and Quarterly Financial Reporting

Policy 4.2

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 1, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	September 26, 2017	**Next Review Date:**	September 2020

Purpose

In furtherance of Council's responsibility to monitor and assess the financial performance of the College, this Policy sets out the content of the College's Financial Plan, its Annual Budget and quarterly financial reports. This Policy also sets out the process for their review by the Finance and Audit Committee and their review and approval by Council.

General

The Financial Plan is a projection based on known and assumed factors and provides Council a view of expected financial scenarios over a three-year period to facilitate the performance of their risk management responsibilities. The Annual Budget provides a plan of financial performance for the immediate next fiscal year and serves as a key accountability document to assess financial performance for that year.

The Council reviews and approves an annual operational and capital budget for the immediately following fiscal year and reviews and approves in principle a Financial Plan for the coming three years, including the year to which the annual budget relates. Each quarterly financial report prepared by management during a fiscal year compares an approved annual budget to actual results, forecasts revenue and expenses for the year and explains the causes of variances between the budget and actual results and the effects of variances on planned activities, if any.

Policy

Financial Plan and Annual Budget:

1. Before the beginning of a new fiscal year, management shall provide the Finance and Audit Committee with a Financial Plan which includes an Annual Budget.

2. The Annual Budget shall contain, at a minimum, the following items:

    a. Expected membership-related revenues;
    b. Expected interest from investments;
    c. Expected miscellaneous revenues;
    d. Detailed line-by-line analysis of planned operational expenses;
    e. Detailed line-by-line analysis of planned projects for the year;
    f. Planned financial results at the end of the year; and
    g. Detailed line-by-line analysis of planned capital assets acquisitions for the year.

3. The Financial Plan for the two years following the year to which the Annual Budget relates shall contain, at a minimum, the following items:

    a. Expected membership-related revenues;
    b. Expected interest from investments;
    c. Expected miscellaneous revenues;
    d. Expected operational expenses;
    e. Expected projects for the year; and
    f. Expected capital assets acquisitions for the year.

4. The Financial Plan and the Annual Budget shall be developed using sound financial data and assumptions.

5. The Finance and Audit Committee shall review and, if appropriate, recommend to Council the approval in principle of the Financial Plan. The Finance and Audit Committee shall review and, if appropriate, recommend to Council the approval of the Annual Budget. The Annual Budget will include an operational and capital budget for the immediately following fiscal year.

6. The Financial Plan and the Annual Budget, including the operational and capital budget, submitted to the Council shall be at a summary level presented in accordance with the categories appearing in the College's latest audited Statement of Operations.

7. The Council shall consider and, if appropriate, approve the Financial Plan, including the Annual Budget, in the following manner:

    a. The Annual Budget for the immediately following fiscal year shall be approved and shall be used as a basis for monitoring financial performance; and
    b. The Financial Plan shall be approved in principle.

Quarterly Financial Reporting

1. Within 75 days of the end of a quarter, management shall provide the Finance and Audit Committee with a Quarterly Financial Report.

2. The Quarterly Financial Report shall contain, at a minimum, the following information:

    a. Statement of Revenue and Expenses showing, by category of revenue and expense, actual revenue and expenses for the period ended in a quarter and forecasted revenue and expenses for the year;
    b. Variance Report showing, by category of revenue and expense, the difference between the forecasted revenue and expenses for the year and the annual budget;
    c. Balance Sheet as at the end of the quarter; and
    d. Budget and Capital Expenditures for the period ended in a quarter.

3. The Finance and Audit Committee shall review the Quarterly Financial Report and report to Council on the financial performance of the College at the next Council meeting following the meeting at which the Finance and Audit Committee reviewed the Quarterly Financial Report.

4. The Council shall consider the report from the Finance and Audit Committee and the Quarterly Financial Report presented at the Council meeting.

5. There is no requirement for the 4th quarter Financial Report to be prepared by management since the performance results will be available through audited financial statements.

6. The Statement of Revenue and Expenses shall show revenue and expenses at a summary level presented in accordance with the categories appearing in the College's latest audited Statement of Operations.

7. Management shall analyze and explain variances from budget as follows:

a. Variances of less than 5% shall not require explanation;
b. Variances of between 5% and 9% shall be explained detailing the causes of the variances and the effects of the variances on planned activities, if any; and
c. Variances of 10% and over shall be explained as in (b) above and may result in discussion with and recommendations to the Finance and Audit Committee and/or Council.

8. In forecasting the revenue and expenses that are likely to be earned or incurred respectively during the balance of the year, management shall apply rational and valid assumptions.

9. For practical considerations, the Statement of Revenue and Expenses shall not include investment gains or losses, whether realized or unrealized.

10. To ease the administrative burden, the deferred revenue line of the Balance Sheet which relates to unearned membership fees will be shown at the value determined in the previous year's audited financial statements.

11. The Budget and Capital Expenditure for the period shall compare actual spending and variance to budget and management shall provide an explanation of any variance and the effects of the variances on planned activities, if any.

12. The format of the Quarterly Financial Report shall be determined by the Finance and Audit Committee.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Expense, Honoraria and Claim Policy

Policy 4.3

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 1, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	December 7, 2018	**Next Review Date:**	September 2020

Purpose

The purpose of this Policy is to set out the practices followed by the College for the payment of honoraria (per diem remuneration) and the reimbursement of expenses incurred while individuals are carrying out their duties as Professional Councillors or Non-Council Committee Members of the College, or carrying out other work requested by the College. It also sets out the process used for verifying claims related to the payment of honoraria and reimbursement of expenses.

Application

This Policy applies to:

- Professional Councillors
- Non-Council Committee Members
- individual members of the College who have been requested by the College to assist on project work of the College

The policies for Publicly-Appointed Councillors (those members of Council appointed by the Lieutenant Governor in Council) are determined by the Ministry of Health and Long-Term Care (MOHLTC) and honoraria and reimbursement of expenses are paid directly by the MOHLTC.

Principles

Reimbursement of expenses shall be guided by the following principles:

i. The expenses incurred relate to College business;
ii. The College's financial resources are to be used prudently and responsibly;
iii. Expense claims are supported by documented evidence of costs incurred; and
iv. Claims are approved by another person to promote accountability.

Policy

Within the ambit of the above principles and subject to any terms and conditions set out below, the College shall pay the applicable daily per diem fee only to Professional Councillors and Non-Council Committee Members (referred to hereinafter as "members") carrying out College business and shall reimburse the individuals to whom this Policy applies (referred to hereinafter as a "claimant" or "claimants") for the following expenses as they relate to College business:

1. Reasonable and convenient mode of transportation from a claimant's home to the meeting place and return;
2. If a claimant uses a personally owned automobile, the number of kilometres at the approved rate for travel to and from their place of residence and the meeting ~~and home~~;
3. Reasonable overnight hotel accommodation during the time necessary for a claimant to carry out College business;
4. Necessary telephone calls for business and reasonable personal calls made during overnight stays in hotel accommodation;
5. Internet expenses incurred for business and reasonable personal purposes during overnight stays in hotel accommodation;
6. Reasonable out of pocket costs for personal meals while on College business provided that, where costs for personal meals are not supported by invoices, a daily maximum of $45.00 will be allowed; and
7. Registration costs for seminars and courses where a claimant is representing the College.

The College shall not reimburse a claimant for:

a. Cost of alcoholic beverages; and
b. Cost of personal entertainment, such as in-hotel movies.

1. Honoraria

Honoraria are paid to members on a per diem basis in accordance with the by-laws of the College ~~By-law No. 4 as amended by By-law No. 34~~. A "per diem" is the amount that is payable for conducting the formal business of the College (e.g. attending a meeting or hearing). Preparation time and travel time are not included in the duration of a meeting and are not paid.

Note that only one (1) full per diem may be claimed in any 24-hour period, regardless of the number of hours or activities involved.

The per diem for meetings over three hours in a single day is as follows:

1. President (or person chairing a Council or committee meeting): $250.00
2. Vice-President: $175.00

3. Attendance at a Council or committee meeting: $150.00
4. Attendance at other meetings representing the College at the request of the College: $150.00

The per diem for meetings of three hours or less in a single day is as follows:

1. President (or person chairing a Council or committee meeting: $125.00
2. Vice-President: $87.50
3. Attendance at a Council or committee meeting: $75.00
4. Attendance at other meetings representing the College at the request of the College: $75.00

Electronic Meetings

~~From time to time, f~~For reasons of economy and/or timeliness, the ~~CMRTO~~ College may holds meetings ~~via interactive electronic communication media~~in a manner that allows all persons participating to communicate with each other simultaneously and instantaneously (e.g. telephone conference calls). As long as ~~such electronic meetings~~meetings held by electronic communication represent a duly constituted ~~meeting of~~ Council or ~~a~~ committee meeting (i.e. booked and minuted by the College), the attending or participating member may request payment of an honorarium at a rate referred to above.

Expenses incurred in respect of conducting ~~electronic~~ Council or committee meetings held by electronic communication are the responsibility of, and reimbursable by, the College.

Conferences/Educational Sessions

Members are expected to develop a working knowledge regarding the business of the College, the Council and any committees to which they are appointed, and to maintain the currency of such knowledge. It may be necessary or advantageous to attend a conference or educational session that is directly related to the business of the College, especially to the specific functions or tasks assigned to the member. The College supports the attendance of members at conferences or educational sessions. An honorarium of $150.00 per day for a conference or educational session over three hours, or $75.00 per day for a conference or educational session of three hours or less, will be provided by the College. Attendance at such conferences/educational sessions must be pre-approved by the Executive Committee.

Speaking Engagements

It may be appropriate for members to undertake speaking engagements relating to their appointment (in general) or issues relating to the committee to which they are appointed. Such speaking engagements must be pre-approved by the Executive Committee.

Per diems payable for local speaking engagements shall be paid on the same basis as the applicable per diem for meetings. Members receiving a per diem from the College shall not

accept an honorarium from any other organization for a speaking engagement where such activity directly results from their appointment.

Honoraria Summary and Conditions

Item	Allowable Claim	Conditions
Full-day meeting or hearing, etc. *(meeting period over three hours)*	President/Chair $250.00 Vice-President $175.00 Professional Councillor $150.00 Non-Council Committee Member $150.00	Only one full per diem may be claimed in any 24-hour period, regardless of the number of hours or activities involved.
Partial day meeting, hearing, etc. *(meeting period equal to or less than three hours)*	**50% of per diem** President/Chair $125.00 Vice-President $ 87.50 Professional Councillor $ 75.00 Non-Council Committee Member $ 75.00	
~~Electronic Meetings~~Meetings held by electronic communication *(duly constituted meeting)*	Same as above	Eligible expenses payable by the College.

Members who live more than ~~150~~ 40 km from the College's head office may choose to travel for the meeting the night before. In this case, the College will pay for the associated hotel accommodation and meal allowance.

2. Expenses

Receipts

Original receipts indicating the expense amounts actually incurred are required, except with respect to mileage for personal vehicles.

Travel

Claimants are encouraged to choose the most efficient, effective and/or economical mode of transportation to and from meetings. While modes of transportation other than the most economical may be used for reasons of personal convenience, reimbursement will be based on the most economical practical mode of transportation.

When rail or air travel is required for meetings which are regularly scheduled, or scheduled far enough in advance to allow for it, claimants are asked to pre-book their travel to take advantage of discount or excursion fares.

a. Surface Transportation

Travel by train or bus is encouraged when the time and distances involved warrant use of these transportation modes. Where possible, claimants should book or reserve seats in advance to take advantage of discount or excursion fares. Where a meeting is being held in the city in which the claimant lives, the use of local public transit is encouraged.

b. Taxis

Local taxis may be used when warranted by weather conditions, physical mobility limitations, the transportation of baggage or parcels, or timeliness.

c. Air Travel

The maximum payable for travel by commercial air carriers is the economy class rate.

d. Rental Cars

The College does not normally pay for the use of rental cars. In exceptional circumstances, when a car rental is required, the prior authorization of the President or Registrar & CEO must be obtained.

e. Personal Vehicles

Where a personally-owned vehicle is used, the claimant will be reimbursed at $0.40 per km. Reasonable charges for parking will be reimbursed. Claimants using personal vehicles for

College business are responsible for ensuring that their insurance coverage includes business use of said vehicle. Personal accident insurance expenses are not reimbursable.

f. Traffic Violations

Under no circumstances will claimants be reimbursed for traffic or parking violations.

g. Vehicle Repair

Under no circumstances will claimants be reimbursed for the cost of vehicle repairs incurred as a result of vehicle breakdowns or accidents which occur while travelling on College business.

h. Travel Outside Ontario

Reimbursement for travel outside Ontario but within Canada and the continental United States requires the prior written approval of the Executive Committee.

Accommodation

a. Hotels

Claimants who are required to travel out of town and overnight to attend to College business may be accommodated in a hotel or motel for the duration of the trip. However, hotel/motel accommodation is not generally provided to individuals who reside within a radius of 40 km of the meeting site. Claimants travelling on College business are required to obtain the lowest available hotel rate. In establishments that do not have an agreed "Corporate rate", the maximum appropriate rate should be the applicable College "Corporate rate".

For College meetings, the College has a corporate account at a nearby hotel.

b. Private Homes

Claimants travelling on College business in a locale where they have relatives or friends may, if they so wish, stay with them rather than seek accommodation in a hotel/motel. The claimant may request reimbursement of a payment, up to a maximum of $25.00 per night, made in recognition of hospitality extended in private accommodation. However, a receipt is required to claim the allowance.

3. Claim Approval

Claims for honoraria and expenses must be submitted on the appropriate forms to the College. Claim forms are available from the College. Claim forms must be signed by the claimant and all required receipts or other information should be attached. Failure to sign the form or to attach required receipts will delay processing of reimbursement claims. Reimbursement will be made only for expenses actually incurred.

All claims for reimbursement shall be approved by the Registrar & CEO except where claims exceed $25,000.00, in which case either the President or the Vice-President shall countersign the approval. Processing of completed and signed claims for honoraria and reimbursement of expenses submitted by claimants usually takes five to ten business days from the date they are received by the College.

Claimants must submit claims for honoraria and expenses for payment no later than four weeks after the meeting/hearing, etc. to facilitate reimbursement. This is especially important for elected/appointed members who are nearing the end of their term or whose term has expired. Claims not so submitted are subject to not being reimbursed in whole or in part.

It is important that claims relating to the period immediately before the end of the College's fiscal year (December 31st) be submitted within two weeks of that date so that they are eligible for payment out of that fiscal year's allocation. Claims not so submitted are subject to not being reimbursed in whole or in part.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Cheque Signing Authority

Policy 4.4

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 05, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Purpose

The purpose of this policy is to set out the authority for signing cheques and other orders for the payment of money on behalf of the College, against the College's bank account.

Policy

Any one of the Registrar & CEO, President or Vice-President alone is authorized on behalf of the College to sign, endorse, make, draw and/or accept any cheques, drafts and any orders for the payment of money provided that the amount is equal to or less than $25,000.00.

Two of the Registrar & CEO, President and Vice-President together are authorized on behalf of the College to sign, endorse, make, draw and/or accept any cheques, drafts and any orders for the payment of money for an amount greater than $25,000.00.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Corporate Credit Card — Policy 4.5

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 01, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	September 26, 2017	**Next Review Date:**	September 2020

Purpose

The Council of the College has approved the acquisition and use of a corporate credit card. The purpose of this policy is to establish standard practices for the administration and use of the corporate credit card.

Policy

1. The College shall obtain only one corporate credit card with a credit limit of $25,000.00.

2. The use of the corporate credit card shall be limited to College business expenses approved by the Registrar & CEO.

3. The corporate credit card shall not be used to circumvent applicable College purchasing and expense recording procedures.

4. The Registrar & CEO shall be responsible for reviewing the monthly corporate credit card statement and verifying the accuracy of the credit card charges on the statement.

5. The use of the corporate credit card shall not exceed its $25,000.00 limit.

6. The outstanding balance on the corporate credit card shall be paid by the due date to avoid any interest payment.

7. The Registrar & CEO shall be the sole custodian of the corporate credit card and shall be responsible for maintaining the highest level of security over it.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Executive Limitation Policy

Policy 4.6

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 01, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	Changed from Policy 1.8 to 4.6 on March 8, 2015	**Next Review Date:**	September 2020

Introduction

The Council is accountable for all activities of College. However, the Council recognizes that there is a distinction between its role as a governing body and the role of the Registrar and Chief Executive Officer (Registrar & CEO) as the sole employee accountable to the Council regarding operational matters.

In addition to any limitations that may be set by any applicable legislation, regulations and by-laws (in this Policy, legislation, regulations and by-laws are collectively referred to as "legislation") and policies of the College, this Executive Limitation Policy sets out the boundaries of prudent ethical behaviour within which the Registrar & CEO shall operate.

General Executive Constraints

The Registrar & CEO shall neither cause nor allow any organizational practice, activity or decision that is imprudent, unethical, unlawful or in violation of commonly accepted business practices or business ethics or that contravenes the legislation governing the affairs of College or the policies of the College.

Mission

The Registrar & CEO shall neither cause nor allow any organizational practice, activity or decision unless it directly or indirectly furthers the College's mission which is to regulate the profession to serve and protect the public interest.

Strategic Priorities

The Registrar & CEO shall not fail to establish and maintain appropriate structures, systems and processes, the purpose of which is to enable the College to attain its strategic and financial plans.

The Registrar & CEO shall not fail to inform the Council in a timely manner regarding the progress towards achieving approved plans.

Employees

The Registrar & CEO shall not cause or allow employee working conditions or hiring practices which are unfair, undignified, inequitable, unsafe, or in contravention of employment standards set out in legislation or the Ontario Human Rights Code.

Risk Management

The Registrar & CEO shall not fail to establish and maintain appropriate systems, processes and practices, the purpose of which is to enable identification, mitigation and management of risks that can adversely affect the College's financial and non-financial assets, reputation, operational continuity and public image.

Succession Planning

In order to protect the College from the unforeseeable or sudden loss of organizational leadership, the Registrar & CEO shall not fail to keep other senior staff members familiar with issues and processes relating to the operation of the College, and shall not fail to facilitate knowledge transfer within the organization.

Public Image

The Registrar & CEO shall neither cause nor allow any organizational practice, activity or decision which may endanger the College's public image and credibility.

Support Infrastructure

The Registrar & CEO shall not fail to establish and maintain effective infrastructure systems that assist the Council and the committees established by Council in carrying out their roles and responsibilities. Accordingly, the Registrar & CEO shall not permit systems, processes or practices that fail to provide relevant, appropriate and timely information to Council and the committees established by Council.

This Policy does not limit the authority of Council to establish other limitations on the role and responsibilities of the Registrar & CEO.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Investment Policy

Policy 4.7

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 01, 2015	**Last Reviewed:**	September 2017
Amended Date(s):	June 19, 2015 September 26, 2017	**Next Review Date:**	September 2020

Purpose

This Policy sets out the criteria and procedures for the management of the investments of the College. The College will invest the funds that are not currently required for the current operations of the organization. This Policy permits sufficient flexibility to optimize investment opportunities and demonstrates the College's commitment to exercising prudence and care in the management of its investments.

Policy

1. Duties and Responsibilities

a. The Council is responsible for the management of the College's investments. The Council shall review and revise this Policy in accordance with the review schedule set by Council.

b. The Finance and Audit Committee shall provide oversight of the College's investments in accordance with the guidelines and criteria set out in this Policy. The Finance and Audit Committee may, within its mandate, recommend to Council:
   i. The amount of the College's surplus funds that may be invested from time to time;
   ii. The classes and types of investment in which the funds may be invested;
   iii. The appointment of an external Investment Advisor to manage the investments; and
   iv. The format of a quarterly performance report regarding the investments.

2. Investment Guidelines and Criteria

a. The College's investment objective is to preserve and enhance the College's investments in order to provide a stable source of funds to support the following:
   i. Payment of unforeseen expenditures arising from the operations of the College;

ii. Keeping revenues stable as circumstances warrant; and
iii. Funding of projects as approved by Council from time to time.

b. The Council will invest the funds that are not required for the current operations of the College in such investments as would be made by any prudent person with their own resources, having regard to the following criteria:
   i. **Preservation of Capital**: The investment portfolio shall be invested with the primary focus on the preservation of capital;
   ii. **Rate of Return**: The investment portfolio shall have an objective of earning a rate of return equal to or above the rate of inflation over a rolling three-year period;
   iii. **Liquidity:** The investment portfolio shall remain sufficiently liquid to meet the College's cash flow requirements that are able to be reasonably anticipated. Accordingly, the portfolio shall be structured so that investments mature concurrently with anticipated cash demands;
   iv. **Diversification:** The investment portfolio shall be sufficiently diversified so that no single investment can have a disproportionate impact on the performance of the overall portfolio; and
   v. **Risk:** The risk profile for the investment portfolio shall be low to medium risk.

c. The Finance and Audit Committee will make recommendations to Council on the investment of the funds that are not required for the current operations of the College.

3. Types of Investments

a. Without limiting the generality of the guidelines and criteria set out in this Policy, the College's investment portfolio shall be limited to the following:
   i. Cash;
   ii. Treasury bills issued by Canadian governments (federal and provincial);
   iii. Acceptances guaranteed by Schedule I and Schedule II banks or bearer deposit notes issued by Schedule I or Schedule II banks or Guaranteed Investment Certificates;
   iv. Commercial paper issued by Canadian corporations with a Standard & Poor's rating of at least A-1 or Dominion Bond Rating Service (DBRS) rating of R-I (low) or better;
   v. CDIC (Canada Deposit Insurance Corporation) eligible High Interest Saving Accounts;
   vi. Bonds and debentures issued by or unconditionally guaranteed by the Government of Canada, the government of any province of Canada or any municipal corporation in Canada;
   vii. Schedule I bank bonds, subordinated debentures, or deposit notes with a Standard & Poor's or DBRS rating of at least A+; and
   viii. Bonds issued by Canadian corporations with a Standard & Poor's or DBRS rating of BBB+ or better.

4. Investment Reporting

a. The Finance and Audit Committee shall monitor and review the performance of the investments at least every quarter and shall report to Council on its monitoring and review.

b. The investment monitoring process shall include, but is not limited to, the following factors:
   i. Continued relevance of investment guidelines and criteria set out in this Policy;
   ii. Compliance with the criteria set out in this Policy;
   iii. Rate of return earned by the portfolio;
   iv. Amount of any fees charged by the Investment Advisor;
   v. Any material change in the Investment Advisor's operational structure or personnel;
   vi. Any breaches or possible breaches of the terms of the agreement between the College and the Investment Advisor or other applicable laws and regulations; and
   vii. Any significant issues and risks to the College.

c. The Finance and Audit Committee shall meet with the Investment Advisor as it deems necessary to review the performance of the investments.

5. Investment Advisor

a. The Council may select and appoint an Investment Advisor for the purpose of investing all or part of the College's surplus funds in accordance with the provisions set out in this Policy.

b. Should the Council determine to use the services of an Investment Advisor, the Finance and Audit Committee may search for a suitable advisor and make a recommendation to Council.

c. The selection process for an Investment Advisor shall include interviews of potential advisors so that the Finance and Audit Committee can be satisfied that the advisor is able to comply with the investment guidelines and criteria set out in this Policy, and to demonstrate sufficient and appropriate due diligence. An Investment Advisor's ability to provide clear, timely and understandable performance reports tailored to the needs of the College shall be one of the key factors in the selection of an Investment Advisor.

d. The Finance and Audit Committee shall monitor and, at least once every three years, evaluate the performance of the Investment Advisor and make a recommendation to the Council on whether to continue to engage or replace the current Investment Advisor.

e. There shall be a written agreement between the College and the Investment Advisor that sets out the investment guidelines and criteria, provides a copy of the Investment Policy to the Investment Advisor, and provides confirmation by the Investment Advisor that they

will follow the provisions set out in the Investment Policy and the guidelines and criteria established by Council.

College of Medical Radiation Technologists of Ontario
Ordre des technologues en radiation médicale de l'Ontario

Salary ranges for College staff

Policy 4.8

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 01, 2015	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

The College is committed to attracting and retaining highly qualified employees. The purpose of this Policy is to provide effective, equitable, and market relevant rates of compensation to College staff. It is intended that the salary ranges permit the College to offer compensation which compares favourably with comparable regulatory bodies.

Application

This Policy applies to all College staff, with the exception of the Registrar & CEO.

Policy

The salary ranges for College staff will be established annually by Council, based on recommendations made by the Executive Committee.

Set out below is a description of the process for the review of salary ranges for College staff.

1. Market Review of Salary Ranges for College Staff

The Executive Committee determines in a particular year whether or not to perform a market review of the salary ranges for College staff. If the Executive Committee decides that a market review should be performed, the Registrar & CEO shall conduct, or arrange to have conducted, a market review of the salary ranges for College staff, at least every three to five years.

2. Review of Salary Ranges for College Staff

Each year at a meeting prior to the review by the Finance and Audit Committee of the proposed annual budget, the Executive Committee will consider whether to recommend a

change in the salary ranges for College staff, having regard to the findings of the market review, if conducted, and whether there has been a change in the cost of living.

3. Calculation of the Change in the Cost of Living

The change in the cost of living will be calculated, based on the percentage change increase over 12 months in the August All-Items Consumer Price Index (CPI) for Canada published by Statistics Canada.

4. Procedure

At the meeting referred to in section 2, the Executive Committee will review the market review, if conducted, and the calculation of the change in the cost of living and will consider whether to recommend to Council any change in the salary ranges for College staff and, if so, the amount of any proposed change(s).

The Executive Committee will notify the Finance and Audit Committee of its recommendations regarding the salary ranges for College staff, and the amount of any proposed change(s), if any, which the Finance and Audit Committee will consider when it reviews the proposed annual budget.

The Executive Committee will forward its recommendations regarding the salary ranges for College staff, and the amount of any proposed change(s), if any, to Council for consideration by Council when Council reviews and approves the annual budget.

The Executive Committee retains the absolute discretion not to recommend any change in the salary ranges for College staff in any given year.

The Council retains the absolute discretion to determine the salary ranges for College staff including, without limiting the generality of the foregoing, the discretion not to approve any change in the salary ranges for College staff in any given year.

5. Effective Date of Change to Salary Ranges for College Staff

If the Council approves a change(s) in the salary ranges for College staff for the following year, such change(s) normally will be applied to the salary ranges as of January 1 of that year.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Process to Review the Salary Range for the Position of the Registrar & CEO and the Registrar & CEO's Salary

Policy 4.9

Section:	Finance and Risk	**Public:**	No
Approved Date:	December 09, 2014	**Review Schedule:**	Every 3 Years
Effective Date:	January 01, 2015	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

The purpose of this Policy is to provide a process to review the salary range for the position of the Registrar & CEO of the College and to review the Registrar & CEO's salary in accordance with the Registrar & CEO's employment contract.

1. Definitions

"Review Group" means a sub-group of the Executive Committee that is composed of the President and two other members of the Executive Committee, who have been appointed by the Executive Committee.

2. Responsibilities of the Executive Committee

The responsibilities of the Executive Committee under this Policy are to:

a. Establish the Review Group in accordance with the composition described in section 1.
b. Determine in a particular year whether or not to perform a market review of the salary range for the position of Registrar & CEO.
c. Conduct, or arrange to have conducted, a market review of the salary range for the Registrar & CEO's position at least every three to five years, as applicable.

d. Consider the findings of the market review and determine whether to recommend to Council an adjustment to the salary range for the Registrar & CEO's position, as applicable.
e. Determine, after consideration of the recommendations of the Review Group, whether or not to adjust the Registrar & CEO's annual salary, the amount of the adjustment, if any, within the salary range approved by the Council and the effective date for the adjustment, if any.

3. Responsibilities of the Review Group

The responsibilities of the Review Group under this Policy are to determine whether or not to recommend to the Executive Committee that the Registrar & CEO's annual salary be adjusted, the amount of the adjustment, if any, within the salary range approved by the Council and the effective date for the adjustment, if any.

4. Basis for Review of Salary Range for the Position of the Registrar & CEO

It is intended that the salary range for the position of the Registrar & CEO permit the College to offer compensation which compares favourably with comparable regulatory bodies. The Council retains the absolute discretion to determine the salary range for the position of the Registrar & CEO including, without limiting the generality of the foregoing, the discretion not to approve any changes in the salary range for the position of the Registrar & CEO in any given year.

5. Process for Review of Salary Range for the Position of the Registrar & CEO

a. The Executive Committee determines in a particular year whether or not to perform a market review of the salary range for the position of the Registrar & CEO.
b. If the Executive Committee decides that a market review should be performed, the Executive Committee conducts, or arranges to have conducted, a market review of the salary range for the Registrar & CEO's position at least every three to five years.
c. As applicable, the Executive Committee considers the findings of the market review, determines whether to recommend an adjustment to the salary range for the Registrar & CEO's position to the Council.
d. If a market review has not been performed in a particular year, the Executive Committee considers whether to recommend to the Council an adjustment to the salary range for the Registrar & CEO's position for that year.
e. Council determines whether or not to approve an adjustment to the salary range for the position of the Registrar & CEO.
f. The Executive Committee retains the absolute discretion not to recommend any adjustment in the salary range for the position of the Registrar & CEO in any given year.
g. The Council retains the absolute discretion to determine the salary range for the position of the Registrar & CEO including, without limiting the generality of the foregoing, the discretion not to approve any adjustment to the salary range for the position of the Registrar & CEO in any given year.

h. If the Council approves an adjustment to the salary range for the position of the Registrar & CEO for the following year, such adjustment will normally be applied to the salary range as of January 1st of that year.

6. Process for Reviewing the Registrar & CEO's Salary

a. The Review Group shall review the Registrar & CEO's salary and determine whether or not to recommend to the Executive Committee that the Registrar & CEO's annual salary be adjusted, the amount of the recommended adjustment, if any, within the salary range approved by the Council and the effective date for the adjustment, if any.
b. The Executive Committee, after consideration of the recommendations of the Review Group, determines whether or not to adjust the Registrar & CEO's annual salary, the amount of the adjustment, if any, within the salary range approved by the Council and the effective date for the adjustment, if any.
c. The Review Group retains the absolute discretion not to recommend any adjustment to the Registrar & CEO's annual salary.
d. The Executive Committee retains the absolute discretion to determine the Registrar & CEO's annual salary provided that it is within the salary range approved by the Council, including, without limiting the generality of the foregoing, the discretion not to approve any adjustment to the Registrar & CEO's annual salary.

7. Timing

The objective is for the salary range for the position of the Registrar & CEO to be approved by the Council in December of a year, to be effective January 1st of the next year, if possible, and for the Registrar & CEO's annual salary for that year to be determined by the Executive Committee by the end of April of each year, if possible. Keeping in mind these targets, attached as Schedule "A" is a possible timetable for the review of the salary range for the position of the Registrar & CEO and the Registrar & CEO's salary.

SCHEDULE "A"

POSSIBLE TIMETABLE FOR THE REVIEW OF THE SALARY RANGE FOR THE POSITION OF THE REGISTRAR & CEO AND THE REGISTRAR & CEO'S SALARY

TIMING	Activity
November	Executive Committee determines the composition of the Review Group Executive Committee considers the market review of the salary range for the position of the Registrar & CEO where one has been conducted. Executive Committee determines whether to recommend to Council an adjustment in the salary range for the position of the Registrar & CEO
December	Council determines whether or not to approve an adjustment to the salary range for the position of the Registrar & CEO
January/ February	
February/ March	The Review Group determines whether or not to recommend to the Executive Committee that the Registrar & CEO's annual salary be adjusted, the amount of the recommended adjustment, if any, within the salary range approved by the Council, and the effective date for the adjustment, if any.
March/April	Executive Committee determines whether or not to adjust the Registrar & CEO's annual salary, the amount of the adjustment, if any, within the salary range approved by the Council, and the effective date for the adjustment, if any. Executive Committee determines whether or not to perform a market review of the salary range for the Registrar & CEO's position.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Procurement of Goods and Services Policy

Policy 4.10

Section:	Finance and Risk		
Approved By:	Council	**Public:**	Yes
Approved Date:	December 09, 2016	**Review Schedule:**	Every 3 Years
Effective Date:	December 09, 2016	**Last Reviewed:**	September 2017
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

The purpose of this Policy is to set principles, processes and procedures to guide procurement of goods and services by the College. The Policy shall apply to all procurement including but not limited to: items of operational needs; consulting services; capital assets; and information technology items.

Principles

The procurement of goods and services shall be guided by the following broad principles:

1. The College shall strive to procure goods and services by practicing high standards of business ethics, professional competency and integrity with both suppliers and contractors.

2. Staff involved in procuring goods and services on behalf of the College shall abide by all applicable provincial and federal laws, all relevant College by-laws and policies, and the Conflict of Interest Policy.

3. All types of procurement must adhere to authorization limits assigned by the Registrar & CEO before procurement commitments can be made.

4. All procurement must follow established protocols.

5. Goods and services shall be procured with due regard to economy, efficiency and protection against waste of resources.

6. In certain situations, the College may be restricted for reasons of compatibility, continuity of services, standardization or urgency to procure goods and services not in accordance with the requirements under this Policy. In such cases the College will act in its best interest.

Policy

1. Authority to procure

a. The acquisition of goods and services is fundamental to the efficient operation of the College and represents significant legal and financial commitment. Accordingly, all procurements and financial commitments for goods and services are to be handled only by staff authorized by the Registrar & CEO and within financial limits set in this Policy.

b. The authorized staff shall ensure that all procurements are approved according to College policies, completed in a fair and equitable manner and handled expertly, in order to meet the requirements of the College end-user, while achieving best value. Special provisions relating to emergency occurrences are outlined in Section F of this Policy.

c. Only the Registrar & CEO is authorized to establish accounts with vendors or to commit the College to procurement and pay for goods or services. Furthermore, only the Registrar & CEO is authorized to sign any rental, lease or license agreement or contracts with any vendor, subject to the provisions set out in the Executive Limitation Policy.

2. Conflict of interest

a. All staff involved in procurement shall be familiar with and abide by the College's Conflict of Interest Policy in discharging their responsibilities.

3. Procurement process

a. All procurements shall adhere to the expenditure limits set in this Policy.

b. Authorized staff are responsible for managing the procurement process. End-users must justify the need for an item or service before the procurement process can be initiated.

c. Comparable quotes from at least three vendors, where possible, shall be sought before a decision to procure is made. However, as provided within this Policy, this requirement may not always apply. If it is not possible to obtain two comparable quotes, the Sole Source Approval Form must be completed and approved. (See Appendix A)

d. In deciding the preferred vendor, authorized staff shall consider the vendor whose offer represents the best combination of quality, price and lowest risk to the College. In an effort to achieve maximum value, the authorized staff shall consider utilizing existing pricing and service arrangements to maximize buying leverage and minimize prices. In

determining risk, consultation with other staff may be beneficial to assess past performance of the vendor.

e. The specifications of any purchase must not be developed in such a way as to deliberately favour one vendor over other similar and competent vendors.

4. Authority Limitations

a. Procurement of less than $1,000.00 and travel expenses

i. Travel expenses, regardless of dollar value, including airfare, hotels and registration fees for courses or conferences for individual staff members do not fall within this Policy. Rather, they shall operate within guidelines set in the Expense Policy.

ii. Individual procurement items of less than $1,000.00 can be ordered directly without seeking comparable quotes.

b. Procurement of between $1,000.00 and $25,000.00

i. The authorized staff will determine the most advantageous procurement method for each purchase, which could include purchasing from a preferred vendor based on standing quotes, soliciting quotations from at least three vendors, where possible, or approving a sole source purchase.

ii. A rationale for the decision not to seek quotations from other vendors as the justification for a sole source purchase must be documented.

iii. The purchase limits under this section apply to groups or bundles of goods or service purchases. Staff are prohibited from splitting orders in order to circumvent the limit set in this section.The Registrar & CEO has the final authority to determine if a group of purchases should be bundled in order to determine the appropriate purchasing methodology.

c. Procurement exceeding $25,000.00

i. The Registrar & CEO shall determine the most advantageous procurement method for each purchase or service exceeding $25,000.00. These could include obtaining quotes from at least three vendors where possible, purchasing from a preferred vendor based on standing quotes, soliciting quotations from vendors on the approved vendor listing, or approving a sole source supplier or consultant.

ii. The use of a sole source supplier or consultant shall be determined based on the following factors:

- Ensuring compatibility with existing products or services; recognizing special expertise of a vendor or a consultant; or to ensure compliance with the manufacturer recommendation relating to equipment or software

- Where there is an absence of competition for technical reasons and the goods or services can be supplied only by a particular supplier and no alternative or substitute exists ,
- Where it is prudent to maintain systems integration or methodologies already deployed
- For work to be performed on property by a contractor according to provisions of a warranty or guarantee held in respect of the property or original work

iii. If the Registrar & CEO at his or her sole discretion determines that a sole source arrangement is not justified, the College shall call for a Request for Proposal in accordance with the process set out in section C of this policy.

iv. Contracts awarded for procurement exceeding $25,000.00 shall be signed by the Registrar & CEO and counter-signed by either the President or Vice-President consistent with the Cheque Signing Authority Policy.

5. Contractors for services

The purchase of services is usually more complex than the purchase of goods, as detailed terms and conditions are additionally required for services to ensure:

a. Legal and other risks to the College are minimized
b. Responsibilities and obligations of each party are clearly set out
c. Services are not construed as employment in nature pursuant to Canada Revenue Agency definitions
d. Service deliverables are clearly identified

6. Emergency purchases

The Registrar & CEO may authorize an immediate purchase of any good or service without recourse to this Policy should emergency situations arise such as, but not limited to, the following:

a. Where staff or public safety is in question;
b. Prevention of damage to College property; and
c. Restoration of essential College services.

In a case where the emergency purchase or services are likely to exceed threshold limits under this Policy, the President or Vice-President shall be kept appropriately apprised and their formal approval sought after the emergency.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Sole Source Approval Form

To:	**Date:**
From:	**Estimated Total Cost:**
Name of Recommended Supplier:	

Description of Product or Service

_____

_____

_____

_____

_____

Criteria

The use of a sole source supplier or consultant shall be determined based on the following factors:	Explanation/Justification/Action Taken to satisfy the critera:
a. Ensuring compatibility with existing products or services; recognizing special expertise of a vendor or consultant; or to ensure compliance with the manufacturer recommendation relating to equipment or software	
b. Where there is an absence of competition for technical reasons and the goods or services can be supplied only by a particular supplier and no alternative or substitute exists	

c. Where it is prudent to maintain systems intergration or methodologies already deployed	
d. For work to be performed on property by a contractor according to provisions of a warranty or guarantee held in respect of the property or original work	

Submitted By

Name: _____
(please print)

Title: _____

Signature: _____

Date: _____

Approved By

Name: _____ *(please print)*	**Name:** _____ *(please print)*
Title: Registrar & CEO	**Title:** President or Vice-President
Signature: _____	**Signature:** _____
Date: _____	**Date:** _____

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Registrar's Discretionary Expenditure

Policy 4.11

Section:	Finance and Risk		
Approved By:	Council	**Public:**	No
Approved Date:	March 27, 2018	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2018	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

The College is committed to the prudent and responsible use of its resources. The College recognizes that reciprocity, hospitality, and the development of stakeholder relationships often require expenditure that extends beyond the scope of Policy 4.3, Expense, Honoraria and Claim. The College supports the Registrar & CEO in nurturing productive relationships that support the mission, vision and strategic goals of the organization.

This purpose of this Policy is to ensure that all discretionary expenditure meets standards of probity expected of a professional regulatory college. All discretionary expenditure must be reasonable and have a justifiable business purpose, in light of the College's Strategic Plan.

1.1 Discretionary Expenditure

1.1.1 Hospitality Related Expenditure

Hospitality related expenditure is defined as food/refreshment expenses incurred where an external party is involved, and the purpose of the expenditure is to represent the College, provide reciprocity of hospitality or build stakeholder relationships in pursuit of organizational goals.

All discretionary expenditure related to hospitality is at the discretion of the Registrar & CEO, to be applied in accordance with the purpose of this Policy.

1.1.2 Alcohol

If it is appropriate to purchase alcohol for official hospitality/external events, the expense incurred must be reasonable and justifiable.

All discretionary expenditure related to the purchase of alcohol is at the discretion of the Registrar & CEO, to be applied in accordance with the purpose of this Policy.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Guidelines for members for patients found incapable of making treatment decisions under the HCCA

Policy 5.3

Section:	Professional Practice		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Purpose

A member of the College who proposes a treatment[1] is responsible for obtaining informed consent from either the patient, if capable, or a substitute decision maker, if the patient is found to be incapable. Members who obtain consent have a professional accountability to be satisfied that the patient is capable of giving consent.

Under the *Health Care Consent Act, 1996* (HCCA), the College is required to establish guidelines for members who have found a patient to be incapable. These guidelines set out the information to be provided to the patient, as well as the circumstances and conditions under which the information should be provided. These guidelines have been developed to assist members in their discussions with those patients they find to be incapable under the HCCA. These guidelines apply unless the emergency provisions of the HCCA are applicable.

Policy

1. If the member proposing a treatment determines that the patient is incapable of making the decision and the member believes that the patient is able to understand the information, the

[1] Treatment, in this context, is defined as anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purposes, and includes a course or plan of treatment.

member informs the patient that a substitute decision maker will be asked to make the final decision. This is communicated in a way that takes into account the particular circumstances of the patient's condition and the member-patient relationship.

2. If there is an indication that the patient disagrees with this information, and, if it relates to the finding of incapacity or to the choice of substitute decision maker, the member informs the patient of their options to apply to the Consent and Capacity Board for a review of the finding of incapacity, and/or for the appointment of a representative of the patient's choice.

3. If the patient expresses a desire to exercise these options, the member is expected to provide assistance.

4. If there is an indication that the patient disagrees with the finding of incapacity when the finding was made by another health care practitioner, the member explores and clarifies the nature of the patient's disagreement. If it relates to the finding of incapacity or to the choice of substitute decision maker, the member informs the health care practitioner who made the finding of incapacity and discusses appropriate follow-up with such health care practitioner.

5. The member uses their professional judgment to determine whether the patient is able to understand the information. For example, a young child or a patient suffering advanced dementia is not likely to understand the information. It would not be reasonable in these circumstances for the member to inform the patient that a substitute decision maker is going to be asked to make a decision on their behalf.

6. The member uses their professional judgment to determine the scope of assistance to provide to the patient in exercising their options. The member documents their actions, according to departmental policy.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Professional accountability of members during a work-stoppage

Policy 5.4

Section:	Professional Practice		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Policy

Advice to Members

The expectations of the College regarding the responsibilities of individual members are based on the profession's standards of practice and the professional misconduct regulation made under the *Medical Radiation Technology Act, 1991* (the Act).[1] These responsibilities focus on the health care needs of patients. A breach of any of the standards, guidelines, and regulations could leave a member vulnerable to a complaint.

The College strongly recommends that every member review with their manager, supervisor, and if applicable, union representative, the on-going professional responsibilities which continue in the event of any work-stoppage, lawful or unlawful, which may be undertaken at a given workplace.

Expectations of Professional Accountability

The College's expectations of the conduct of members in the event of a work-stoppage are based on the profession's standards of practice and the professional misconduct regulation made under the Act.

[1] On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiation Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force.

a. Each member is accountable to the public and responsible for ensuring that their practice and conduct meet legislative requirements and the standards of the profession.

b. Members have an obligation not to abandon or neglect patients, or put them at risk of harm. The Council of the College has considered whether a withdrawal of professional services could be considered unprofessional conduct, and has determined that it may be considered to be unprofessional conduct to discontinue professional services unless:

- The patient requests the discontinuation of professional services;
- Alternative or replacement professional services are arranged; or
- The patient is given a reasonable opportunity to arrange for alternative or replacement professional services.

c. The professional misconduct regulation made under the Act provide that failing to meet the standards of practice of the profession is an act of professional misconduct.

d. The professional misconduct regulation made under the Act provide that should a member engage in conduct or perform an act in the course of practising the profession which, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional, such conduct or act constitutes professional misconduct.

The College's Regulatory Responsibility

The College is required to investigate all formal complaints in which a member and the complainant are clearly identified. All formal complaints received by the College are investigated and all information relevant to the complaint is obtained. A decision regarding what action needs to be taken, if any, will be made by the Inquiries, Complaints and Report (ICR) Committee based on all the information and consideration of all the circumstances.

The College may also initiate an investigation into a member's practice if there are reasonable and probable grounds that a member has committed an act of professional misconduct. These investigations are reviewed by the ICR Committee. The ICR Committee has the option to refer a case to the Discipline Committee for a hearing.

Any action the College takes with respect to a member's registration is entirely separate and apart from any action initiated by an employer, or a government agency before an administrative tribunal, such as the Labour Relations Board of Ontario, or the Courts.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Educational programs and examination(s) approved by the College in radiography, radiation therapy and nuclear medicine

Policy 6.1

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Policy

1. Applicants trained in Ontario

The programs listed in Schedule 1 to Ontario Regulation 866/93, as amended (the "Registration Regulation") or considered by the Council of the College to be equivalent to a program listed in Schedule 1 to the Registration Regulation are the approved programs in Ontario. Attached as Schedule 1 to this Policy is a current list of the approved programs in Ontario.

Applicants trained in Ontario must successfully complete the examination set by the Canadian Association of Medical Radiation Technologists (the CAMRT), which is an examination approved by Council.

2. Non-Ontario Canadian Trained Applicants

Council has determined that each of the programs offered in all of the other provinces which has been accredited by the Conjoint Committee for the Accreditation of Educational Programs in Diagnostic Imaging and Medical Radiation Technologies of the Canadian Medical Association, or of 8872147 Canada Inc., a subsidiary of the Canadian Medical Association, or, as of February 1, 2018, Accreditation Canada, an affiliate of Health Standards Organization (the Approved Accreditation Body), is equivalent to the approved programs offered in Ontario.

The accreditation process provides a method of evaluation through regular visits of trained assessors and evaluation of staff, faculties, curriculum and clinical experience.

Any applicant trained in a province other than Quebec must successfully complete the examination set by the CAMRT. Applicants trained in Quebec must successfully complete the examination set by the Ordre des technologues en imagerie médicale, en radio-oncologie et en electrophysiologie medicale du Québec (formerly Ordre des technologues imagerie médicale et en radio-oncologie du Québec). These examinations have been approved by Council.

3. Internationally Educated Applicants

The College has determined that it does not have the resources to adequately assess, on an ongoing and regular basis, the programs and examinations in the profession offered outside Ontario, which are not accredited by the Approved Accreditation Body.

Therefore, it is the policy of the College that, effective January 1, 1998, programs offered outside Canada are not considered by Council to be equivalent to an approved program offered in Ontario and the examinations related to such programs are not approved by Council.

An applicant who has successfully completed a program in one or more of the specialties outside of Canada will be required to satisfy the Registration Committee that the program is substantially similar, but not equivalent, to the approved programs offered in Ontario and that the applicant is competent to practise the profession in Ontario in the specialty, and to successfully complete the examination set by the CAMRT.

4. Application of Policy

This Policy only applies to the following three specialties:

a. Radiography;
b. Radiation therapy; and
c. Nuclear medicine.

This Policy does not apply to an applicant (a "labour mobility applicant") who already holds an out-of-province certificate (as defined in the labour mobility provisions of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991*) that is equivalent to a certificate of registration issued by the College in the specialty being applied for, provided that the labour mobility applicant meets the registration requirements under section 5 of Ontario Regulation 866/93, as amended.

SCHEDULE 1

PROGRAMS LISTED IN SCHEDULE 1 OF

ONTARIO REGULATION 866/93 OR CONSIDERED BY COUNCIL

TO BE EQUIVALENT TO A PROGRAM LISTED IN SCHEDULE 1

Radiography

1. Algonquin College of Applied Arts and Technology, Ottawa, Ontario

2. Cambrian College of Applied Arts and Technology, Sudbury, Ontario

3. Collège Boréal D'arts Appliqués et de Technologie, Sudbury, Ontario

4. Collège Cambrian D'arts Appliqués et de Technologie, Sudbury, Ontario

5. Confederation College of Applied Arts and Technology, Thunder Bay, Ontario

6. Eastern Ontario School of X-Ray Technology, Kingston, Ontario

6.1 Queen's University/Eastern Ontario School of X-ray Technology Collaborative Program: Bachelor of Science (General) in Life Sciences/Diploma in X-ray Technology, Kingston, Ontario

7. Fanshawe College of Applied Arts and Technology, London, Ontario

8. Mohawk College of Applied Arts and Technology, Hamilton, Ontario

8.1 Mohawk College of Applied Arts and Technology/McMaster University, Collaborative Advanced Diploma - Bachelor of Medical Radiation Sciences Program, Radiography Specialization, Hamilton, Ontario

9. National Defence Medical Centre, Ottawa, Ontario

10. The Michener Institute for Applied Health Sciences, Toronto, Ontario

10.1 The Michener Institute for Applied Health Sciences/University of Toronto, Faculty of Medicine Joint Degree/Diploma Program in Medical Radiation Sciences-Radiological Technology (formerly The Michener Institute for Applied Health Sciences/University of Toronto, Faculty of Medicine Joint Degree/Diploma Program in Radiation Sciences-Radiological Technology Stream), Toronto, Ontario

Nuclear Medicine

11. The Michener Institute for Applied Health Sciences, Toronto, Ontario

11.1 The Michener Institute for Applied Health Sciences/University of Toronto, Faculty of Medicine Joint Degree/Diploma Program in Medical Radiation Sciences-Nuclear Medicine Technology (formerly The Michener Institute for Applied Health Sciences/University of Toronto, Faculty of Medicine Joint Degree/Diploma Program in Radiation Sciences-Nuclear Medicine Stream), Toronto, Ontario

Radiation Therapy

12. The Michener Institute for Applied Health Sciences/University of Toronto, Faculty of Medicine Joint Degree/Diploma Program in Medical Radiation Sciences-Radiation Therapy Technology (formerly The Michener Institute for Applied Health Sciences/University of Toronto, Faculty of Medicine Joint Degree/Diploma Program in Radiation Sciences-Radiation Therapy Stream), Toronto, Ontario

13. The Michener Institute for Applied Health Sciences/Laurentian University-Radiation Therapy Technology Program, Toronto, Ontario

14. Mohawk College of Applied Arts and Technology/McMaster University, Collaborative Advanced Diploma – BSc Degree Medical Radiation Sciences Program, Radiation Therapy Specialization, Hamilton, Ontario

15. Ontario School of Radiation Therapy/The Princess Margaret Hospital, Toronto, Ontario in co-operation with:

    Kingston Regional Cancer Centre

    Northeastern Ontario Regional Cancer Centre, Sudbury

    Nova Scotia Cancer Centre, Halifax

    Ottawa Regional Cancer Centre

    Saint John Regional Hospital, New Brunswick

    The Princess Margaret Hospital, Toronto

    Thunder Bay Regional Cancer Centre

    Windsor Regional Cancer Centre

16. Hamilton Regional Cancer Centre, Hamilton, Ontario

17. London Regional Cancer Centre, London, Ontario

18. Toronto-Bayview Regional Cancer Centre, Toronto, Ontario.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Educational programs and examination(s) approved by the College in magnetic resonance

Policy 6.2

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Policy

1. Applicants trained in Ontario

The program listed in Schedule 1.1 to Ontario Regulation 866/93, as amended (the "Registration Regulation") or considered by the Council of the College to be equivalent to a program listed in Schedule 1.1 to the Registration Regulation are the approved programs in Ontario. Attached as Schedule 1 to this policy is a current list of the approved programs in Ontario.

Applicants trained in Ontario must successfully complete the examination set by the Canadian Association of Medical Radiation Technologists (the CAMRT), which is an examination approved by Council.

2. Non-Ontario Canadian Trained Applicants

The programs listed in Schedule 1.2 to the Registration Regulation and attached as Schedule 2 to this Policy are the approved programs in Canada that are offered outside Ontario.

An applicant trained in a province other than Ontario must successfully complete the examination set by the CAMRT.

3. Internationally Educated Applicants and Other Applicants Trained in Programs Not Listed in Schedules 1.1 or 1.2 of the Registration Regulation

The program in the specialty of magnetic resonance offered at The Michener Institute of Education at UHN (formerly known as The Michener Institute for Applied Health Sciences), Toronto, Ontario, being the program listed in Schedule 1.1 to the Registration Regulation, has been accredited by the Conjoint Committee for the Accreditation of Educational Programs in Diagnostic Imaging and Medical Radiation Technologies of the Canadian Medical Association, or, as of February 1, 2018, Accreditation Canada, an affiliate of Health Standards Organization (the Approved Accreditation Body).

The accreditation process provides a method of evaluation through regular visits of trained assessors and evaluations of staff, faculties, curriculum and clinical experience. The College does not have the resources to adequately assess, on an ongoing and regular basis, programs in the specialty of magnetic resonance.

The College has determined that, in order for a program in the specialty of magnetic resonance to be considered to be equivalent to the program in the specialty of magnetic resonance offered at The Michener Institute of Education at UHN, Toronto, Ontario, it must be accredited by the Approved Accreditation Body.

Therefore, it is the Policy of the College that, unless a program in the specialty of magnetic resonance is listed in Schedule 1.1 or 1.2 of the Registration Regulation or has been accredited by the Approved Accreditation Body, the program is not considered by Council to be equivalent to the program in the specialty of magnetic resonance offered at The Michener Institute of Education at UHN.

An applicant who has successfully completed a program offered outside Ontario that is not considered by Council to be equivalent to the program in the specialty of magnetic resonance offered at The Michener Institute of Education at UHN will be required to satisfy the Registration Committee that the program is substantially similar, but not equivalent, to the approved program in Ontario and that the applicant is competent to practise the profession in Ontario in the specialty of magnetic resonance, and to successfully complete the examination set by the CAMRT in the specialty of magnetic resonance.

Application of Policy

This Policy only applies to the specialty of magnetic resonance.

SCHEDULE 1

PROGRAMS LISTED IN SCHEDULE 1.1

OF ONTARIO REGULATION 866/93 OR CONSIDERED BY COUNCIL

TO BE EQUIVALENT TO A PROGRAM LISTED IN SCHEDULE 1.1

Magnetic Resonance

1. Cambrian College of Applied Arts and Technology, Sudbury, Ontario
2. Fanshawe College of Applied Arts and Technology, London, Ontario
3. The Michener Institute for Applied Health Sciences, Toronto, Ontario

SCHEDULE 2

PROGRAMS LISTED IN SCHEDULE 1.2

OF ONTARIO REGULATION 866/93 AS AMENDED

OR CONSIDERED BY COUNCIL

TO BE EQUIVALENT TO A PROGRAM LISTED IN SCHEDULE 1.2

Magnetic Resonance

1. British Columbia Institute of Technology, Burnaby, British Columbia
2. Northern Alberta Institute of Technology – Diploma Program, Edmonton, Alberta
3. Northern Alberta Institute of Technology – Post Diploma Program, Edmonton, Alberta
4. Queen Elizabeth II/Dalhousie School of Health Sciences, Halifax, Nova Scotia
5. Red River College of Applied Arts, Science and Technology, Winnipeg, Manitoba

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Approved examination in the specialties of radiography, radiation therapy, nuclear medicine and magnetic resonance

Policy 6.3

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	December 8, 2017	**Next Review Date:**	March 2021

Policy

The Council of the College approves the examination set by the Canadian Association of Medical Radiation Technologists as the examination approved by the Council in the specialties of radiography, radiation therapy, nuclear medicine and magnetic resonance pursuant to Sections 4(1)2 and 4.1(1)2 of Ontario Regulation 866/93 as amended. An applicant will be given four attempts to successfully complete the examination.[1]

[1] The effective date of the amendment which replaced "three attempts" with "four attempts", was February 1, 2010.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Approved Examination for applicants trained in Quebec

Policy 6.4

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

The Council approves, pursuant to Section 4(1)(2) of Ontario Regulation 866/93, as amended, the examination set by the Ordre des technologues en imagerie médicale, en radio-oncologie et en electrophysiologie medicale du Québec (formerly Ordre des technologues imagerie médicale et en radio-oncologie du Québec) as the examination approved by Council in the specialties of radiography, radiation therapy and nuclear medicine for applicants who have successfully completed a program in the profession in Quebec in one of the three specialties.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Course in Jurisprudence set and approved by the College

Policy 6.5

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	December 8, 2017	**Next Review Date:**	March 2021

Purpose

Paragraph 7 of subsection 3(1) of Ontario Regulation 866/93 as amended (the "Registration Regulation") requires that an applicant must have successfully completed a course in jurisprudence set or approved by the College.

Policy

For purposes of paragraph 7 of subsection 3(1) of the Registration Regulation, the course in jurisprudence set and approved by the College consists of the following:

1. the College's Legislation Learning Package, as the same may be amended, modified, restated or replaced;

2. the appropriate provincial and federal statutes, regulations, policies and guidelines which relate to the practice of the profession generally and to the particular specialty of the applicant, as the same may be amended, modified, restated or replaced; and

3. the Standards of Practice of the College, as the same may be amended, modified, restated or replaced.

The appropriate provincial and federal statutes, regulations, policies and guidelines for the five specialties are currently:

- *Regulated Health Professions Act* and Regulations (radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography)
- *Medical Radiation Technology Act*[1] and Regulations (radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography)
- *Health Care Consent Act* (radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography)
- *Healing Arts Radiation Protection Act* and Regulations (radiography, radiation therapy, and nuclear medicine)
- The College's Sexual Abuse Prevention Program (radiography, radiation therapy, nuclear medicine, magnetic resonance and diagnostic medical sonography)
- *Nuclear Safety and Control Act* and Regulations (radiation therapy and nuclear medicine)

Successful completion of the course in jurisprudence set and approved by the College means that an applicant reviews:

1. the College's Legislation Learning Package;

2. the appropriate statutes, regulations, policies and guidelines applicable to the practice of the profession generally and to the particular specialty for which the applicant is applying; and

3. the Standards of Practice of the College.

[1] On a date to be named by proclamation of the Lieutenant Governor, the *Medical Radiation Technology Act, 1991* will be repealed. On that date, the *Medical Radiation and Imaging Technology Act, 2017* will come into force.

College of Medical Radiation Technologists of Ontario
Ordre des technologues en radiation médicale de l'Ontario

Employment Specific Certificates of Registration

Policy 6.6

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

It is the policy of the College that Employment Specific members involved in amalgamations or other restructuring of Health Care Facilities be continued on the Register with the previously stipulated scope of practice restrictions.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Approved programs – Cambrian College Magnetic Resonance Program

Policy 6.7

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

Pursuant to subparagraph (i) of paragraph 4.1(1)1 of Ontario Regulation 866/93, as amended (the "Registration Regulation"), the Council of the College hereby approves Cambrian College of Applied Arts and Technology, Magnetic Resonance Imaging Program, as equivalent to a program in the specialty of magnetic resonance listed in Schedule 1.1 of the Registration Regulation.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Approved programs – Algonquin College Radiography Program

Policy 6.8

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

Pursuant to subparagraph (i) of paragraph 4(1)1 of Ontario Regulation 866/93, as amended (the "Registration Regulation"), the Council of the College hereby approves the program titled Algonquin College of Applied Arts and Technology, Medical Radiation Technology, Radiological Technology, as equivalent to a program in the specialty of radiography listed in Schedule 1 of the Registration Regulation.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Approved programs – Fanshawe College Magnetic Resonance Program

Policy 6.9

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

Pursuant to subparagraph (i) of subsection 4.1(1)1 of Ontario Regulation 866/93, as amended (the "Registration Regulation"), the Council of the College hereby approves the program titled Fanshawe College of Applied Arts and Technology, Magnetic Resonance Imaging, as equivalent to a program in the specialty of magnetic resonance listed in Schedule 1.1 of the Registration Regulation.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Educational programs approved by the College in the specialty of diagnostic medical sonography

Policy 6.10

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	December 8, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	January 1, 2018	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Definitions

In this Policy, the following words and phrases have the meanings set out below:

"**Approved Accreditation Body"** means the Conjoint Committee for the Accreditation of Educational Programs in Diagnostic Imaging and Medical Radiation Technologies of the Canadian Medical Association, or of 8872147 Canada Inc., a subsidiary of the Canadian Medical Association, or, as of February 1, 2018, Accreditation Canada, an affiliate of Health Standards Organization.

"**Effective Date**" means the date on which the Registration Regulation comes into force.

"**Registration Regulation**" means the regulation which amends Ontario Regulation 866/93 for the purpose of the regulation of diagnostic medical sonography as a new specialty.

"**Specialty**" means the specialty of diagnostic medical sonography.

Policy

1. Applicants trained in Ontario

On the Effective Date, the programs listed in Schedule 1.3 to Ontario Regulation 866/93 as amended (the Registration Regulation) or considered by the Council to be equivalent to a program listed in Schedule 1.3 to the Registration Regulation are the approved programs in Ontario. Attached as Schedule 1 to this Policy is a list of the approved programs in Ontario as of the Effective Date.

2. Non-Ontario Canadian Trained Applicants

The Council has determined that, as of the Effective Date, each of the programs in the Specialty offered in all of the other provinces which has been accredited by an Approved Accreditation Body is equivalent to the approved programs offered in Ontario. Attached as Schedule 2 to this Policy is a list of the approved programs offered in Canada outside of Ontario as of the Effective Date.

The accreditation process provides a method of evaluation through regular visits of trained assessors and evaluation of staff, faculties, curriculum and clinical experience.

3. Internationally Educated Applicants

The programs in the Specialty as listed in Schedule 1.3 of the Registration Regulation have been accredited by an Approved Accreditation Body.

The accreditation process provides a method of evaluation through regular visits of trained assessors and evaluations of staff, faculties, curriculum and clinical experience. The College does not have the resources to adequately assess, on an ongoing and regular basis, programs in the Specialty.

The College has determined that, in order for a program in the Specialty to be considered to be equivalent to the programs in the Specialty listed in Schedule 1.3 of the Registration Regulation, the program must be accredited by an Approved Accreditation Body.

Therefore, it is the Policy of the College that, unless a program in the Specialty is listed in Schedule 1.3 of the Registration Regulation or has been accredited by an Approved Accreditation Body, the program is not considered by Council to be equivalent to the programs in the Specialty listed in Schedule 1.3 of the Registration Regulation.

An applicant who has successfully completed a program offered outside Ontario that is not considered by Council to be equivalent to the programs listed in Schedule 1.3 of the Registration Regulation, will be required to satisfy the Registration Committee that the program is substantially similar, but not equivalent, to an approved program in Ontario and that, based on satisfactory evidence of a type approved by the Registration Committee and in the form and manner approved by the Registration Committee, the applicant is competent to practise the profession in Ontario in the Specialty.

Application of Policy

This Policy only applies to the Specialty.

This Policy does not apply to an applicant (a "labour mobility applicant") who already holds an out-of-province certificate (as defined in the labour mobility provisions of the Health Professions Procedural Code) that is equivalent to a certificate of registration issued by the CMRTO in the Specialty, provided that the labour mobility applicant meets the registration requirements under section 5 of Ontario Regulation 866/93, as amended.

SCHEDULE 1

PROGRAMS LISTED IN SCHEDULE 1.3 OF ONTARIO REGULATION 866/93

Diagnostic Medical Sonography

1. Algonquin College of Applied Arts and Technology (General Sonography), Ottawa, Ontario

2. BizTech College of Health Sciences, Business and Technology (Cardiac and Vascular Sonography), Mississauga, Ontario

3. Cambrian College of Applied Arts and Technology (General Sonography), Sudbury, Ontario

4. Canadian National Institute of Health (General Sonography), Ottawa, Ontario

5. Collège Boréal d'arts appliqués et de technologie (Échographie générale), Sudbury, Ontario

6. Mohawk College of Applied Arts and Technology (Diagnostic Cardiac Sonography), Hamilton, Ontario

7. Mohawk College of Applied Arts and Technology/McMaster University – Collaborative Advanced Diploma – Bachelor of Medical Radiation Sciences Program – Ultrasound Specialization (General Sonography), Hamilton, Ontario

8. St. Clair College of Applied Arts and Technology (General Sonography), Windsor, Ontario

9. The Michener Institute of Education at University Health Network (General Sonography), Toronto, Ontario

SCHEDULE 2

PROGRAMS OFFERED OUTSIDE OF ONTARIO AND CONSIDERED BY COUNCIL TO BE EQUIVALENT TO A PROGRAM LISTED IN SCHEDULE 1.3 OF ONTARIO REGULATION 866/93

Diagnostic Medical Sonography

1. Northern Alberta Institute of Technology (Generalist and Cardiac Sonography), Edmonton, Alberta

2. Southern Alberta Institute of Technology (Generalist and Cardiac Sonography), Calgary, Alberta

3. British Columbia Institute of Technology (General and Cardiac Sonography), Burnaby, British Columbia

4. Red River College (Cardiac Sonography), Winnipeg, Manitoba

5. Red River College (General Sonography), Winnipeg, Manitoba

6. College of the North Atlantic, Prince Philip Drive Campus (General Sonography), St. John's, Newfoundland

7. Queen Elizabeth II/Dalhousie School of Health Sciences - Diploma and Degree Options (General, Cardiac and Vascular Sonography), Halifax, Nova Scotia

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Approved examinations for the specialty of diagnostic medical sonography set and administered by Sonography Canada

Policy 6.11

Section:	Registration		
Approved By:	Council	**Public:**	Yes
Approved Date:	December 8, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	January 1, 2018	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Definitions

In this Policy, the following words and phrases have the meanings set out below:

"**Area of Practice**" means each of general sonography, cardiac sonography and vascular sonography.

"**Effective Date**" means the date on which the Registration Regulation comes into force.

"**Four Attempts**" means, by reference to a specified examination, four attempts to complete that examination successfully.

"**Registration Regulation**" means the regulation which amends Ontario Regulation 866/93 for the purpose of the regulation of diagnostic medical sonography as a new specialty.

"**Specialty**" means the specialty of diagnostic medical sonography.

Policy

1. For the purpose of section 4.2(1)2 of Ontario Regulation 866/93 as amended, on the Effective Date, the Council approves, as the examinations approved by the Council in the Specialty, the following examinations set and administered by Sonography Canada:

   (a) For all Areas of Practice within the Specialty, the core sonography examination.

   (b) For general sonography, the generalist sonographic examination, being composed of:

      (i) obstetrical and gynecological sonography,

      (ii) abdominal sonography; and

      (iii) generalist vascular sonography.

   (c) For cardiac sonography, the cardiac sonographic examination.

   (d) For vascular sonography, the vascular sonographic examination.

2. For the purpose of section 4.2(1)2 of Ontario Regulation 866/93 as amended, on the Effective Date, the Council approves that:

   (a) an applicant whose Area of Practice within the Specialty is general sonography must successfully complete all of the examinations described in paragraph 1(a) and subparagraphs 1(b)(i), (ii) and (iii).

   (b) an applicant whose Area of Practice within the Specialty is cardiac sonography must successfully complete both of the examinations described in paragraphs 1(a) and 1(c).

   (c) an applicant whose Area of Practice within the Specialty is vascular sonography must successfully complete both of the examinations described in paragraphs 1(a) and 1(d).

3. For the purpose of section 4.2(1)2 of Ontario Regulation 866/93 as amended, on the Effective Date, the Council approves that:

   (a) an applicant for a certificate of registration in the Specialty will be given Four Attempts for the examination described in paragraph 1(a).

   (b) an applicant whose Area of Practice within the Specialty is general sonography will be given Four Attempts for each examination described in subparagraphs 1(b)(i), (ii) and (iii).

   (c) an applicant whose Area of Practice within the Specialty is cardiac sonography will be given Four Attempts for the examination described in paragraph 1(c).

(d) an applicant whose Area of Practice within the Specialty is vascular sonography will be given Four Attempts for the examination described in paragraph 1(d).

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Quality Assurance Portfolio: Percentage of Members

Policy 7.1

Section:	Quality Assurance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	December 7, 2018	**Next Review Date:**	March 2021

Policy

It is the Policy of the College that the percentage of members who are randomly selected each year to make their Quality Assurance (QA) Portfolio[1] available to the QA Committee or an assessor appointed by the QA Committee for assessment, shall be approved by resolution of Council.

[1] ~~The QA Committee has approved the QA Portfolio as the form in which members must record their self-assessments and participation in continuing education or professional development activities.~~ Effective January 1, 2018, the QA Committee has approved the QA ePortfolio as the form in which members must record their self-assessments and participation in continuing education or professional development activities. For the period up to and including December 31, 2017, the QA Committee had approved the QA Portfolio as the form in which members must record their self-assessments and participation in continuing education or professional development activities, which included either the ePortfolio or the QA Portfolio (Print Version).

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Peer and Practice Assessment by Multi-Source Feedback (MSF) or by an Assessor: Percentage of Members

Policy 7.2

Section:	Quality Assurance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	[Amended Date]	**Next Review Date:**	March 2021

Policy

It is the Policy of the College that the percentage of members who are randomly selected each year to undergo a peer and practice assessment by means of a multi-source feedback system or by an assessor in accordance with the Quality Assurance (QA) Committee's practice of random selections for assessment, shall be approved by resolution of Council.

College of Medical Radiation Technologists of Ontario
Ordre des technologues en radiation médicale de l'Ontario

Random selection without replacement

Policy 7.3

Section:	Quality Assurance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	December 8, 2015	**Next Review Date:**	March 2021

Background

The Quality Assurance (QA) Committee may randomly select members of the College to submit their QA Portfolio[1] each year. The QA Committee may also randomly select members to undergo a peer and practice assessment each year. The peer and practice assessment may be conducted by means of a multi-source feedback assessment or by an assessor. The QA Committee may also require members to submit their QA Records at any time.

Purpose

The purpose of this Policy is to clarify the random selection process for both the selection of members to undergo a peer and practice assessment and the selection of members to submit their QA Portfolio. This Policy is not intended to affect the authority of the QA Committee or an assessor to require members to submit their QA Portfolio at any time or to order a peer and practice assessment under other circumstances.

Policy

The random selection process for the selection of members to undergo a peer and practice assessment or to submit their QA Portfolio will be conducted as a process of random selection

[1] Effective January 1, 2018, the QA Committee has approved the QA ePortfolio as the form in which members must record their self-assessments and participation in continuing education or professional development activities. For the period up to and including December 31, 2017, the QA Committee had approved the QA Portfolio as the form in which members must record their self-assessments and participation in continuing education or professional development activities, which included either the ePortfolio or the QA Portfolio (Print Version).

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Continuing education and professional development activities

Policy 7.4

Section:	Quality Assurance		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Policy

Each member of the College is required to participate in at least twenty-five (25) hours of continuing education or professional development activities each year as part of the Quality Assurance (QA) Program in order to maintain the knowledge, skills and judgment required to practise the profession in accordance with the Standards of Practice and Code of Ethics set by the College.

The QA Committee may accept partial hours to fulfill this requirement if a member holds a certificate of registration for less than an entire QA year.[1]

[1] The QA year runs from January 1 to December 31.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Publication of Discipline decisions

Policy 8.2

Section:	Professional Conduct		
Approved By:	Council	**Public:**	Yes
Approved Date:	March 27, 2015	**Review Schedule:**	Every 3 Years
Effective Date:	March 27, 2015	**Last Reviewed:**	March 2018
Amended Date(s):	March 27, 2018	**Next Review Date:**	March 2021

Policy

1. No discipline decision (including its reasons) will be published in the newsletter of the College and on the College website until the thirty (30) day appeal period has expired;

2. If, after the expiry of the thirty (30) day appeal period, no appeal has been filed by the member, the decision and reasons will be published in the newsletter of the College and on the College website, and the member's name will be published if otherwise permitted by Section 56(2) of the Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991.*

3. If the member has given notice of an appeal within the thirty (30) day appeal period, the decision and reasons will be published in the newsletter of the College and on the College website, but the member's name will not be published until the appeal has been disposed of.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Workplace Health & Safety

Policy 9.1

Section:	Human Resources		
Approved By:	Council	**Public:**	No
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	March 27, 2018	**Next Review Date:**	September 2020

Policy

The College is committed to protecting and promoting the health and safety of all employees and visitors.

This Policy is designed to protect and promote the health and safety of all employees and visitors, and to reduce the risk of property damage and equipment loss.

Orientation for all new employees shall include an overview of this Policy along with related health and safety procedures. All employees shall complete the College's Safety Checklist, contained in the Employee Handbook, on an annual basis. It is the responsibility of all staff to comply with this Policy and all related procedures.

The College shall designate a Health & Safety representative from among the employees.

1.1 Workplace Hazards

All employees have a responsibility for maintaining a safe work environment in order to protect and promote the health and safety of all employees and visitors. Once a physical hazard has been identified, an employee shall correct the situation. If a correction requires additional resources not available to the employee, direction should be obtained from the Registrar & CEO or designated director. Maintenance issues shall be reported to the property management office responsible for managing the premises or the Health & Safety representative.

All employees shall also ensure that:

- exits and corridors are unobstructed
- objects, including corporate files, are not left lying on floors
- cables and wires are not hazardously placed, but rather properly secured
- filing cabinet drawers and cupboard doors are closed when not in use
- appropriate breaks are taken from work at computer terminals to prevent injuries and to reduce muscle strain
- any spills in the kitchen (or elsewhere) are mopped up immediately
- all entrance doors are locked after-hours
- the entrance door is locked while no employee is positioned at the Reception Desk
- any injuries sustained in the workplace are immediately reported to the Registrar & CEO or designated director
- noxious fumes, trip hazards or other hazards (e.g. faulty electrical, leaking pipes, etc.) are appropriately managed

1.2 Occupational Health & Safety

1.2.1 Workplace Hazardous Materials Information Systems (WHMIS)

All employees shall be aware of the location of the WHMIS Manual (the Manual) and be aware of the contents of the Manual. It is the responsibility of all employees to be aware of the legislation as outlined in the Manual.

The Material Safety Data Sheets for all hazardous materials located and used in the College offices are kept in the Manual (i.e. laser printer and photocopier toner).

1.2.2 Smoke Free Environment

The College provides a smoke free work environment.

1.2.3 Fragrance Free Environment

The College provides a fragrance free work environment to minimize the potential adverse allergic and/or medical reactions that can occur among employees and visitors. No personal fragrance products are to be used at the College by employees, Councillors, or Non-Council Committee Members. Visitors will be advised of the policy through signage and are also expected to comply. Personal fragrance products include, but are not limited to: perfume, cologne, aftershave and body spray, hair spray, soap, fabric softener, mothballs, shampoo and conditioners, lotions and creams, oils, and air fresheners and deodorizers. If a complaint results from the use of personal fragrance products, the complainant should either remind the individual of this Policy or bring the issue to the attention of the Registrar & CEO or designated director.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Emergency Preparedness & Response

Policy 9.2

Section:	Human Resources		
Approved By:	Council	**Public:**	No
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Policy

The College is committed to protecting and promoting the health and safety of all employees and visitors.

This Policy is designed to protect and promote the health and safety of all employees and visitors, by ensuring that employees are aware of the steps to be taken in the event of an emergency.

1.1 Fire Safety

All employees must be familiar with the fire procedures as outlined in the Employee Handbook.

After evacuation in accordance with the procedure, all employees must meet at the meeting area as set out in the Employee Handbook, in order to determine that all employees are accounted for.

The Fire Marshal for the College offices is the Registrar & CEO or designated staff person.

1.2 Medical Emergency

In the event that an employee is injured at work, the Registrar & CEO or designated director must be informed immediately. All employees should be aware of the location of the First-Aid kit. If an employee requires medical attention, the Registrar & CEO or designated director will ensure that the employee is given the appropriate assistance to get to a medical facility.
In the event of a serious emergency, employees shall follow this procedure:

- Call 911. Tell them your building address, floor and suite number.

- While awaiting medical assistance, keep the person warm and comfortable.
- Attempt to obtain the individual's name and address, as well as the name and phone number of their supervisor and/or family member(s) who may have to be notified.

In addition to the general procedure set out above, employees shall follow any building-specific emergency procedures as set out in the Employee Handbook.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Personal Information Privacy

Policy 9.3

Section:	Human Resources		
Approved By:	Council	**Public:**	No
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Policy

The College is committed to safeguarding the personal information privacy of all employees.

The College collects personal information regarding employees for purposes related to their employment with the College including but not limited to, the provision of compensation and benefits, emergency contact and statutory filings. The College only uses the personal information of its employees for legitimate purposes related to their employment with the College. The College safeguards the personal information it collects about employees and only discloses it with the consent of the employee or where required by law. Employees are entitled to access and correct the personal information the College has collected regarding them. Any concerns regarding the manner in which the College has collected, used or disclosed personal information about its employees should be directed to the Registrar & CEO.

The College is also committed to a policy of complete confidentiality with respect to personnel records.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Leaves of Absence and Sick Time

Policy 9.8

Section:	Human Resources		
Approved By:	Council	**Public:**	No
Approved Date:	November 9, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	November 9, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	March 27, 2018	**Next Review Date:**	September 2020

Policy

1. Leaves of Absence

The College is committed to complying with the leave of absence requirements set out in the *Employment Standards Act, 2000* (the ESA). This Policy is not an exhaustive list of all leaves of absence available under the ESA. Employees are encouraged to consult the legislation for exceptions and additional information.

1.1. Bereavement Leave

Up to three (3) days of leave is available to any employee attending the funeral of an immediate member of the family. "Immediate member of the family" means a spouse, child, mother, father, sister, brother, grandfather, grandmother, grandchild, father-in-law or mother-in-law of the employee. One (1) day of leave is available to employees attending funerals of other relatives. If travel of more than 500 km is required to attend the funeral, two (2) additional days of bereavement leave may be granted. Special circumstances are reviewed at the Registrar & CEO's discretion.

1.2. Pregnancy/Parental Leave

Any employee employed for at least thirteen (13) weeks prior to the expected date of delivery is eligible for ***unpaid*** Pregnancy Leave of seventeen (17) weeks. Pregnancy Leave, which is to begin no earlier than 17 weeks before the expected delivery date, is governed by the ESA. Pregnancy Leave lasts for a maximum of 17 weeks after Pregnancy Leave begins.

To obtain the leave, the employee must give the College at least two (2) weeks' notice in writing, and provide a statement from a legally qualified medical practitioner stating that they are pregnant and the estimated date of delivery. Notice of intention to return to work is also required and, if the date of return is less than six (6) weeks after the child's birth, should include a

medical certificate stating that the employee is able to resume normal duties. Written notice must be given at least four (4) weeks before the day the employee wishes to end their leave if an employee wishes to end their leave early.

Any permanent employee employed at the College for at least one (1) year prior to the expected date of delivery is eligible to receive 20% of their basic salary for a period of seventeen (17) weeks. For an employee to be eligible to receive this sum for a subsequent Pregnancy Leave, that employee must have a total of 600 or more hours of insurable employment in their qualifying period.

Under the provisions of the ESA, employees are entitled to ***unpaid*** Parental Leave if they have completed thirteen (13) weeks of employment. Parental Leave is to begin immediately following Pregnancy Leave where applicable, or, in the case of employees not entitled to Pregnancy Leave, no more than seventy-eight (78) weeks after the day the child is born or comes into the custody, care and control of a parent for the first time. An employee who has taken Pregnancy Leave is entitled to thirty-five (35) weeks of Parental Leave. An employee who has not taken Pregnancy Leave, such as an adoptive parent, is entitled to thirty-seven (37) weeks of Parental Leave.

In addition, an employee who has completed at least thirteen (13) weeks of employment prior to the expected date of delivery or the date the child is born or comes into the custody, care and control of a parent for the first time is eligible to extend their ***unpaid*** Parental Leave from thirty-five (35) to sixty-one (61) weeks for employees who take pregnancy leave, and from thirty-seven (37) to sixty-three (63) weeks otherwise. An employee must provide notice of their intention to take Parental Leave and the duration of said Parental Leave two (2) weeks prior to the commencement of their Parental Leave.

Any permanent employee employed at the College for at least one (1) year prior to the expected date of delivery or the date the child is born or comes into the custody, care and control of a parent for the first time is eligible to receive 20% of their basic salary for a period of thirty-five (35) weeks for employees who take Pregnancy Leave, and for a period of thirty-seven (37) weeks otherwise. For an employee to be eligible to receive this sum for a subsequent Parental Leave, that employee must have a total of 600 or more hours of insurable employment in their qualifying period.

In addition, an employee employed at the College for at least one (1) year prior to the expected date of delivery or the date the child is born or comes into the custody, care and control of a parent for the first time is eligible to extend their Parental Leave from thirty-five (35) to sixty-one (61) weeks for employees who take Pregnancy Leave, and from thirty-seven (37) to sixty-three (63) weeks otherwise. An employee must provide notice of their intention to take Parental Leave and the duration of said Parental Leave two (2) weeks prior to the commencement of their Parental Leave.

In the case of both Pregnancy and Parental Leave, vacation days continue to accrue. See Policy 1.3, Staff Vacation and Holidays for more information.

For exceptions and additional information, consult the ESA. Further details can be obtained from the Registrar & CEO or designated director.

1.3. Personal Emergency Leave Days

Under the provisions of the ESA, all employees are entitled to ten (10) personal emergency leave days per calendar year.

Employees of the College are entitled to paid days of leave for the first four (4) of the ten (10) personal emergency leave days available under the ESA. The four (4) paid personal emergency leave days are to be used for medical appointments, a personal illness, injury or medical emergency, mental health days, an urgent matter involving a family member, etc. Unused personal emergency leave days cannot be carried forward from one year to the next.

Employees are permitted to take ***paid*** personal emergency leave days in ½ day increments. To be clear, if an employee wishes to take this ½ day in the afternoon, the hours to be worked are from 8:00 to 11:30 with no break period. If an employee wishes to take this ½ day in the morning, the hours to be worked are from 12:30 to 4:00 with no break period.

Unpaid personal emergency leave days cannot be taken in half day increments. If an employee takes any part of a day as unpaid leave under this section, the College will deem the employee to have taken one day of unpaid leave on that day.

Employees are only entitled to four (4) paid personal emergency leave days if they have been employed for at least one (1) week.

Although a statement from a legally qualified medical practitioner is not required for personal emergency leave, the College may require an employee to provide evidence that is reasonable in the circumstances.

1.4. Unpaid Leave

The Registrar & CEO ***may*** grant a leave of absence under exceptional circumstances. Each request will be considered on its merits. An employee requiring unpaid leave should put the request in writing for consideration by the Registrar & CEO.

1.5. Jury and Witness Duty

Employees called for jury duty or subpoenaed as witnesses may be paid full salary during that period at the discretion of the Registrar & CEO. In the event employees are paid full salary during that period, under reasonable circumstances, they will be expected to attend work during times they are not required by the court. Any fees paid for jury service or witness fees are to be remitted to the College, with the exception of transportation payments. Employees will not receive any pay if they are required to perform jury or witness duty during their probationary period.

1.6. Time Off to Vote

Employees are entitled under the law to have three clear hours before polls close, or after polls open, to vote in federal and provincial elections. Employees requiring such time should make every effort to vote at the beginning or end of the working day to minimize disruption to their work.

2. Sick Time

During each calendar year, employees of the College are entitled to up to eight (8) paid sick days to be used when an employee is personally sick or injured. Unused sick days cannot be carried forward from one year to the next.

Employees are responsible for notifying their supervisor and/or the Registrar & CEO or designated director of their absence no later than 9:30 a.m.

When an employee exceeds the number of sick days they have remaining, and they are not yet on short-term disability, then either:

(i) The employee can keep their pay at 100% by using personal emergency leave days, banked overtime or vacation days; or,
(ii) The employee's pay will be reduced to reflect the day(s) not worked.

This means that if an employee has used all sick, personal emergency leave and vacation days, and has no banked overtime, then if the employee is off sick for a day, they will not be paid for that day.

With the exception of the personal emergency leave days available to employees under section 1.3 above, the College will not compensate any new employees who are absent from work during the first three (3) months of continuous employment with the College.

A statement from a legally qualified medical practitioner is required for each absence in excess of three (3) working days, and periodically for long-term absences, depending on the nature of the disability. Without this statement, an employee may not be eligible to be paid for the time away from work. The College reserves the right to waive, by written notice, the requirement for a statement from a legally qualified medical practitioner.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Records and Information Management Program Policy

Policy 10.1

Section:	Privacy and Information Management		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Purpose

The Records and Information Management Program Policy outlines in detail how the College complies with its legal and operational obligations and requirements to manage records and information in its custody and control. This Policy shall promote the efficient creation, use, maintenance, retention and disposal of records and information and shall ensure that records and information are retained or disposed of according to legal and statutory requirements. The authority for the Records and Information Management Program Policy derives from the Records and Information Management Policy.

Policy statement

Electronic records and information are part of the usual and ordinary course of business of the College.

In order to establish the integrity and authenticity of records and information under the College's custody and control, electronic records and information shall be recorded in a records and information management system. The College's Records and Information Management Program Policy shall provide evidence of:

- the authenticity of the record or information;

- the integrity of the records and information management system the record or information was recorded or stored in; and
- that the record or information was made in the usual and ordinary course of business.

In doing so, the requirements for the admissibility of electronic records as documentary evidence in a legal proceeding are satisfied.

The Records and Information Management Administrator shall implement the Records and Information Management Program Policy in the usual and ordinary course of business of the College.

Any changes or revisions to the Records and Information Management Program Policy must be approved by the Council.

Application

This Policy applies to all records and information within the custody or control of the College, including records and information where an electronic record is intended to replace an original paper document and be accepted as documentary evidence in a legal proceeding. This Policy also includes, but is not limited to: records and information management systems, databases and business information systems. This Policy does not apply to service providers.

Content

The Records and Information Management Procedures Manual establishes clear organizational standards for the management of records and information from creation to disposal or permanent retention.

To ensure the admissibility of records and information as documentary evidence in legal proceedings, electronic records must comply with the National Standard of Canada, *Electronic Records as Documentary Evidence* CAN/CGSB-72.34-(2005).[1]

The Records and Information Management Procedures Manual is supported by the following approved documents: the Records and Information Management Policy; the Records and Information Management Program Policy; the Records and Information Retention Policy; the

[1] CAN/CGSB-72.34 specifies principles and procedures for creating all forms of electronic records to enhance their admissibility as evidence in legal proceedings. Admissibility under electronic record provisions such as s. 31.2(1)(a) of the *Canada Evidence Act* and s. 34.1(5) and (5.1) of the *Ontario Evidence Act* require proof of the integrity of the electronic records system by or in which the electronic record was recorded or stored. The requirements for establishing the integrity of a records management system are defined by CAN/CGSB-72.34. For the full text of the Standard, consult www.publications.gc.ca/site/eng/287649/publication.html.

Records and Information Retention Schedule; the Retention Schedule Management documents; the Digitization Process Manual; the College's Operations Manual; and the Information Security Policies.

The Records and Information Retention Schedule and accompanying management documents outline the procedures and process for:

- Record types authorized for capture and maintenance by the records management system
- Record types not authorized for capture or maintenance by the records management system
- Electronic information retention
- Electronic information disposition and destruction
- Retention scheduling
- Information disposition and destruction
- Indexing, registering and profiling

Built in features of the Electronic Document Management System provide:

- Audit trails
- Version control
- Change control and maintenance of documentation
- Updating procedures for the procedures manual
- Authenticated output procedures

The Operational Manual details the process and procedures for the creation of records and workflows. Self modifying files are not in use.

The Digitization Manual contains processes for document scanning, data and record capture and electronic document quality assurance.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Records and Information Management Policy

Policy 10.2

Section:	Privacy and Information Management		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):		**Next Review Date:**	September 2020

Purpose

The College is committed to establishing and maintaining records and information practices that meet legal and operational obligations and requirements.[1] The College is also committed to establishing and maintaining records and information practices that support efficiency, transparency and accountability.

The purpose of the Records and Information Management Policy is to establish clear organizational standards for the management of records and information from creation to disposal or permanent retention.

This Policy applies to all records and information within the custody or control of the College, including records and information where an electronic record is intended to replace an original paper document and be accepted as documentary evidence in a legal proceeding. This Policy also includes, but is not limited to: records and information management systems, databases and business information systems. This Policy does not apply to service providers.

[1] For the purpose of this Policy, "records" are information created, received, and maintained by the College for business purposes, legal obligations, or both, regardless of medium or form.

Policy statement

Records and information are essential in the usual and ordinary course of business of the College. The availability of reliable and authentic information and records supports the delivery of service to College members and stakeholders.

To ensure the admissibility of records and information as documentary evidence in legal proceedings, electronic records must comply with the National Standard of Canada, *Electronic Records as Documentary Evidence* CAN/CGSB-72.34-(2005).[2]

To ensure the admissibility of electronic records and information as documentary evidence in a legal proceeding, once a record has been quality controlled and determined satisfactory, the original paper source must be shredded and disposed of within an established time frame. The only exception will be those records defined as having permanent value, which will be sent to an off-site storage facility for long-term preservation.

The Records and Information Management Policy is supported by the following approved documents: the Records and Information Management Program Policy; the Records and Information Management Program Procedure; the Records and Information Retention Policy; the Records and Information Retention Schedule; the Information Security Policy; the Digitization Process Manual; and the College's Operations Manual.

[2] CAN/CGSB-72.34 specifies principles and procedures for creating all forms of electronic records to enhance their admissibility as evidence in legal proceedings. Admissibility under electronic record provisions such as s. 31.2(1)(a) of the *Canada Evidence Act* and s. 34.1(5) and (5.1) of the *Ontario Evidence Act* require proof of the integrity of the electronic records system by or in which the electronic record was recorded or stored. The requirements for establishing the integrity of a records management system are defined by CAN/CGSB-72.34. For the full text of the Standard, consult www.publications.gc.ca/site/eng/287649/publication.html.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Records and Information Retention Policy

Policy 10.3

Section:	Privacy and Information Management		
Approved By:	Council	**Public:**	Yes
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Purpose

The Records and Information Retention Policy ensures that all records and information within the custody or control of the College are properly created, used, maintained, retained or disposed of according to legal and operational obligations and requirements.

This Policy aides College staff in understanding their obligations in maintaining all records and information, including, but not limited to: records management systems, databases and business information systems.

This Policy authorizes the creation of the Records and Information Retention Schedule, which sets out the instructions for the maintenance, retention and disposal of records and information created or obtained by the College in the usual and ordinary course of business.

Policy statement

The College shall create and maintain accurate, reliable and authentic records and information that can be audited as required. The College shall use, retain and dispose of said records and information according to legal and operational obligations and requirements.

The Records and Information Management Administrator is authorized to carry out the activities required to implement the Records and Information Retention Schedule. The Schedule is based on the value of the record or information as defined by this Policy.

In the event of the commencement of an audit or legal proceeding regarding records or information in the custody or control of the College, College staff will inform the Records and Information Management Administrator immediately. Further disposal of affected records or information will be suspended pending the completion of said audit or legal proceeding.

Definitions

The Records and Information Retention Schedule is based on the value of the record or information. The following value types are used by the College for the purposes of record retention:

- Fiscal value: records and information that pertain to the College's financial transactions. Records and information with fiscal value are required for financial audits.

- Administrative value: records and information created in the course of completing the operational obligations of the College.

- Archival value: records and information with sufficient legal, historical, administrative or informational value to warrant permanent preservation.

- Legal value: records and information that contain evidence of compliance with regulatory and legal obligations.

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Information Security Program

Policy 11.1

Section:	Information Technology		
Approved By:	Council	**Public:**	No
Approved Date:	September 26, 2017	**Review Schedule:**	Every 3 Years
Effective Date:	September 26, 2017	**Last Reviewed:**	[Last Reviewed Date]
Amended Date(s):	[Amended Date]	**Next Review Date:**	September 2020

Purpose

The information security program of the College is a comprehensive program that integrates policies for information security with procedures to maintain the integrity and availability of records and information and information processing facilities.

The Registrar & CEO of the College has overall responsibility for the establishment and governance of the organization's information security program.

The Director responsible for Information Technology services has responsibility for operational oversight and administration of the program.

Senior management has overall responsibility for the protection of College's information assets and each Director is designated as the information owner for the data generated and maintained in each program area.

The co-operation of authorized users is essential for effective security. System users have responsibility for maintaining effective access controls and abiding by policies that establish the security controls relevant to managing the infrastructure assets and services.

Contents

Introduction

This document provides an overview of the various programs and processes that form the College's information security program for the protection of College information assets. Many areas of any organization's security program play key roles in protecting the information assets.

The security program was built from the applicable laws, regulations, and standards by developing various organizational policies and programs that create the overall program. The organization's policies and activities that make up the security program are the responsibility of senior management within College, not the sole responsibility of one individual. The Registrar & CEO has overall responsibility for the organization's information security program.

Legislative Framework and Standards

The integrity of all College electronic records is a function of the integrity of the record management system. The College's records management system in founded on the National Standard of Canada for electronic records management *(Electronic Records as Documentary Evidence CAN/CGSB – 72.34-2005*). The security controls relevant to managing the infrastructure assets and services are loosely based on the *ISO27001- Information Security Management Systems – Requirements* standard. The use of ISO27001 does not have meaning in the context of formal auditing, compliance or certification in relation to the standard but has been used to identify required security controls to manage security risks and vulnerabilities.

The College is required under legislation to comply with the privacy and confidentiality requirements of the *Regulated Health Professions Act, 1991* (RHPA) and has voluntarily adopted a Privacy Code to provide a mechanism through which the College can provide appropriate privacy rights to individuals involved in the College's activities while still enabling the College to meet its statutory mandate under legislation.

Supporting Programs and Policies

The College has a number of different policies and programs related to information and record management. These policies and programs directly or in-directly support the College information security program and the periodic evaluation and audit of the College's information systems. The following policies play a role in the overall protection of the College's records and information assets and form part of the overall security program.

Senior management has overall responsibility for the protection of the College's information assets. The College's information security program is a comprehensive program that begins with an organizational information security policy that establishes, at a high-level, the purpose and scope of the program and defines different organization roles and responsibilities by position. Specific additional policies establish support for additional areas that play a role in protecting the College's information assets.

During the periodic evaluation and audit process of the College's systems, these policies are used as a reference point to validate that the applications and overall system infrastructure meets the requirements outlined within these policies. The policies that play a role in protecting the College's information assets include:

- Operational
- Systems access management
- Environment and asset management
- System monitoring
- Risk management
- Third party management
- System development
- Human resource
- Business continuity
- Security incident management

The information security program also includes information technology specific procedures to support the above policy requirements and the online operations manual that establishes standards and guidelines for College staff related to operationalizing some of the policy requirements.

Training and Awareness Program

The information security program depends on the responsibility and actions of the College staff in performing the duties outlined in the policy which help in protecting the organization's information assets. The information security program includes a training program where College staff are trained in their security responsibilities. This program is established through the organization's human resources policies for information security. This advises staff that the College's senior management feels that security is important and that everyone will be held accountable for their actions.

The College's information security training is one of the most important aspects of computer and information security, building on awareness. An effective training and awareness program reduces the number of accidental security incidents because people are more conscious of general security issues.

The training program informs the system users of the organization's security policies and practices, what is expected of the users, and how the users are to handle the organization's information, data, and systems. The training program will provide the relevant and needed security skills and competency to enable the organization's contractors and partners to perform their jobs more effectively. Topics are not limited and change as technology advances.

System Documentation

As a part the College's system development life cycle (SDLC) process, the development of documentation specific to the system is an important component of the information security program. The documentation outlines the system from development to production. The documentation includes the items identified below.

- system functional requirements
- database software configurations
- operating system configurations
- user application configuration
- system architecture (physical)
- data flows (logical)
- user manuals
- system security plan
- a disaster recovery/business continuity plan
- service level agreements required for system maintenance and support.

This documentation supports the College's information security program by providing authorized and qualified individuals the ability to understand the system configurations and operational state. This assists problem-isolation thereby reducing system downtime, and provides a baseline for the development of enhancements for the system in the future. Having the correct

documentation available reduces dependency on the individual(s) who developed the system. The information owner is responsible to ensure that adequate documentation is developed, maintained, and available to the appropriate people.

Business Recovery Plan

At the College, the business recovery plan consists of two main areas: a Business Continuity Management Plan (BCMP) and a Disaster Management Plan (DMP). The two areas are established to ensure that the College's critical business processes are maintained to support the mission of the organization. The BCMP focuses primarily on the College's IT systems and consist of the actions that must be taken before, during and after a disruption for each system supporting a business process to minimize the impact, and includes contingency plans for critical systems, while the DMP provides a strategy to minimize the after effects of a major disruptive event that will likely have an impact that is larger than the College's offices alone and may or may not include the IT component.

While the goals and actions in these plans are extremely important, the people carrying out these activities are the most critical elements. These plans identify that College staff are the most important asset and that loss of life or limb outweighs any loss of information or physical asset owned by the organization. These plans are subject to period testing to provide lessons learned that will be used to strengthen the plans by correcting weaknesses or oversights.

Audit Program

In order to verify that the College record and information management system meets or exceeds the security requirements identified to protect the College's information system and data, periodic audits by an independent party will be conducted.

The method used for verification should consist of five basic steps: identify assets, identify threats and vulnerabilities, collect data (test, inspect, and interview), analyze the data and document the results. Once the results are documented the Registrar & CEO will review and approve, or disapprove the operation of the system based on the results of the verification process.

The audit process consists of activities using established techniques that verify that the system's security controls, as documented in the system's security plan, have been implemented and are effective in mitigating risks to the system. The process takes into consideration a system's operating environment and should identify the other compensating controls in place to protect the system. An outcome of this process is the identification of vulnerabilities within the system and recommendations to correct the vulnerability.

During the audit process a proposed "Fix-it Plan" will be developed and can be used as a management tool for tracking corrective actions that need to be completed to correct the vulnerabilities identified during the system audit.

Ministry of Health and Long-Term Care

Office of the Deputy Minister

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Ministère de la Santé et des Soins de longue durée

Bureau du sous-ministre

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Ontario

October 18, 2018

MEMORANDUM TO: Health Sector Partners

FROM: **Helen Angus**
Deputy Minister
Ministry of Health and Long-Term Care

RE: Ministry Realignment

We are all committed to a patient-centred health care system that is effective and efficient and delivers high quality care for patients. Many of you are rethinking your care pathways and processes to put the patient at the centre of your organization. I believe there is great value in the ministry also organizing itself in a way that better reflects how the health system is organized, making it easier for you and patients to interact with us.

I want you to be aware of some structural changes announced today that will clarify and simplify lines of accountability and allow our organization to be more nimble and outcome focused by:

- Aligning acute and emergency services, bringing hospitals, provincial programs and emergency services together;
- Bringing together community and mental health and addictions services, including integrating youth mental health services;
- Ensuring end-to-end planning and implementation for long-term care homes;
- Integrating capital, workforce and system capacity planning;
- Aligning the Chief Medical Officer of Health with population and public health oversight;
- Combining public drug programs and assistive devices;
- Better connecting the Provincial Chief Nursing Officer with policy to provide strategic clinical nursing expertise on a broad range of health care policy and transformation initiatives. Aligning our policy, research, and innovation work to ensure patient-focused outcomes; and
- Centralizing the responsibilities for LHIN-managed health services under an Associate aligned with key capacity, workforce and planning functions allowing for end-to-end management of health services for better outcomes and improved integration.

Associate Deputy Minister, Health Services (renamed from Delivery and Implementation) Melanie Fraser, who recently joined our ministry, will have the following divisions reporting to her:

- **Acute and Emergency Services** led by Melissa Farrell, Assistant Deputy Minister, including hospitals, quality improvement, provincial programs and emergency health services.
- **Capacity Planning and Capital** led by Michael Hillmer, Assistant Deputy Minister on an interim basis, including health capital investment, capacity planning, health workforce planning and regulatory affairs.
- **Community, Mental Health and Addictions and French Language Services** led by Tim Hadwen, Assistant Deputy Minister, including local health planning and delivery, primary care and home care, as well as child, youth, forensic and justice mental health services. Transfer of programs from the Ministry of Children, Community and Social Services will be effective October 29.
- **Long-Term Care Homes,** led by Brian Pollard, Assistant Deputy Minister, including long-term care home renewal.

Divisions now reporting directly to me as the Deputy Minister include:

1. **Drugs and Devices,** led by Suzanne McGurn, Assistant Deputy Minister, including assistive devices.
2. **Ontario Health Insurance Plan**, led by Lynn Guerriero, Assistant Deputy Minister, including claims services.
3. **Chief Medical Officer of Health and Population and Public Health,** led by Dr. David Williams, including all population and public health programs and services.
4. **Strategic Policy and Planning**, led by Patrick Dicerni, Assistant Deputy Minister, including the Provincial Chief Nursing Officer, health workforce regulatory oversight, and health innovation to embed innovation earlier in the development of our strategic direction.
5. **Corporate Services,** led by Peter Kaftarian, CAO, on an interim basis.
6. **Secretariat for Ending Hallway Medicine,** led by Fredrika Scarth, Director.
7. **Associate Deputy Minister and Chief Information Officer,** led by Lorelle Taylor, Associate Deputy Minister and Chief Information Officer.
8. **Communications and Marketing,** led by Jean-Claude Camus, Assistant Deputy Minister.

As we transition, Sharon Lee Smith, Denise Cole and Roselle Martino will stay on with the ministry on assignments to support priority areas. Sharon Lee will lead the ministry Indigenous engagement efforts ensuring there is stability in our key relationships and addressing any critical issues. Denise will lead the ministry in setting up an expedited review of legislation and regulation to identify impediments to more effective and efficient operations of the health system and the ministry in its oversight role. Roselle will continue to advise on the opioid strategy.

Included in this email is a link to our new organizational chart.

I would like to take this opportunity to thank you in advance for your partnership and collaboration. Today's announcement will ensure we are ready to work with you on the challenges and opportunities ahead.

Sincerely,

Helen Angus

CIRCULATED WITH AGENDA OF DEC 07 2018 COUNCIL ITEM# 7aii

CIRCULATED WITH AGENDA OF NOV 08 2018 EXECUTIVE ITEM# 6civ

Kirusha Kobindarajah

From: Ontario News <newsroom@ontario.ca>
Sent: October 19, 2018 2:03 PM
To: Linda Gough <LGough@CMRTO.org>
Subject: Statement from Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care

Ontario Newsroom

Statement

Statement from Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care

October 19, 2018

The Ministry of Health and Long-Term Care has undergone an organizational realignment, as part of our government's plan to tackle the ongoing hallway healthcare crisis in our health care system. Some divisions and branches will be merged to better serve patients. These changes will clarify and simplify lines of accountability and allow our organization to be more nimble and outcome-focused.

These changes will streamline patient care and are the first steps towards enhancing the quality and efficiency of our health system. Our government will continue to listen to and consult with patients and the people who work on the front lines of our health care system to develop an integrated, modern and effective model of care that Ontarians need and deserve.

This organizational change will help ensure our government is able to fulfill our promise of developing a patient-centered health care system that is effective and provides the highest quality of care for all Ontarians.

Kirusha Kobindarajah

From: Cole, Denise (MOHLTC) <Denise.Cole@ontario.ca>
Sent: October 18, 2018 8:28 PM
To: info@regulatedhealthprofessions.on.ca; allan.mak@ctcmpao.on.ca; lbetteridge@ocswssw.org; taylor@crto.on.ca; d.adams@crpo.ca; rmorris@cpo.on.ca; rhamilton@collegept.org; nlumwilson@ocpinfo.com; PGarshowitz@collegeoptom.on.ca; fkhan@coptont.org; elarney@coto.org; andrew.parr@collegeofnaturopaths.on.ca; k.dobbin@cmo.on.ca; Linda Gough <LGough@CMRTO.org>; kwilkie@cmlto.com; officeofregistrar@cmto.com; Brenda.Kritzer@coko.ca; basil.ziv@collegeofhomeopaths.on.ca; melisse.willems@collegeofdietitians.org; gpettifer@denturists-cdo.com; jrigby@cdto.ca; ifefergrad@rcdso.org; ltaylor@cdho.org; jpwillson@cco.on.ca; fsmith@cocoo.on.ca; boriordan@caslpo.com; Anne Coghlan <acoghlan@cnomail.org>; nwhitmore@cpso.on.ca
Cc: Henry, Allison (MOHLTC) <Allison.Henry@ontario.ca>; Cheng, Stephen (MOHLTC) <Stephen.Cheng@ontario.ca>; Pinto, Marsha (MOHLTC) <Marsha.Pinto@ontario.ca>; Custers, Thomas (MOHLTC) <Thomas.Custers@ontario.ca>; Dicerni, Patrick (MOHLTC) <Patrick.Dicerni@ontario.ca>; de Braganca, Lorraine (MOHLTC) <Lorraine.deBraganca@ontario.ca>; Collins, Virginia (MOHLTC) <Virginia.Collins@ontario.ca>; Holm, Bruna E. (MOHLTC) <Bruna.Holm@ontario.ca>
Subject: PLEASE READ - Ministry of Health & Long-Term Care Realignment - What it Means for You

Hello Health Regulatory Colleges Colleagues,

By now you may have seen the memo from Deputy Minister Helen Angus making you aware of some structural changes announced today that will clarify and simplify lines of accountability and allow the ministry to be more nimble and outcome focused. The changes impact my division, Health Workforce Planning and Regulatory Affairs, which is one of the divisions that has been merged within the ministry based on the new program structure.

Of relevance to you, the Health Workforce Regulatory Oversight Branch (Allison Henry, Director) has been realigned to the Strategic Policy and Planning Division (SPPD) to allow for centralized expertise of policy and planning. Allison remains the Director of the branch and now reports to ADM Patrick Dicerni. This change is effectively immediately. The branch moves intact to SPPD, hence, there are no changes to its structure and the managers and staff that you have dealt with remain the same.

Turning to me, the Deputy Minister has asked me to lead the ministry in setting up an expedited review of legislation and regulation to identify impediments to more effective and efficient operations of the health system and the ministry in its oversight role. (Perhaps you are not rid of me yet! ☺) I am quite excited by this assignment.

On a personal note, I want to say it has been an absolute joy to work with you and your colleagues. I have learned so much from each of you. I am sure our paths will cross again, but in the meantime as we say in Jamaica "walk good and may good dupy (spirit) walk with you".

Best,
Denise

Denise Cole
Assistant Deputy Minister, Health Workforce Planning & Regulatory Affairs Division
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Kirusha Kobindarajah

From: Ontario News <newsroom@ontario.ca>
Sent: Tuesday, October 23, 2018 11:59 AM
To: bakenny@regulatedhealthprofessions.on.ca
Subject: Ontario's Government for the People Cutting Red Tape in Order to Help Create and Protect Jobs

Ontario Newsroom

News Release

Ontario's Government for the People Cutting Red Tape in Order to Help Create and Protect Jobs

October 23, 2018

Making Ontario Open for Business Act would remove job-killing burdens

TORONTO — Ontario's Government for the People is taking concrete measures to make Ontario open for business, grow the economy and help create and protect good jobs across the province.

Jim Wilson, Ontario's Minister Responsible for Red Tape and Regulatory Burden Reduction, joined Laurie Scott, Minister of Labour and Merrilee Fullerton, Minister of Training, Colleges and Universities, to announce a series of regulatory and legislative changes that, if passed by Ontario's Legislature, will make it easier for Ontario employers to hire and make it easier for workers to find jobs and grow their careers in Ontario.

"When it comes to the economy, being 'For the People' means keeping and growing good jobs right here in Ontario," said Wilson. "This will not happen on its own. Instead it starts with cutting the unnecessary red tape that is driving jobs and investment out of our province."

The *Making Ontario Open for Business Act* will, if passed by Ontario's Legislature, enable more Ontario employers to boost job creation and investment by cutting unnecessary regulations that are inefficient, inflexible and out of date, while maintaining standards to keep Ontarians safe and healthy.

"At the heart of our plan is the conviction that Ontario can once again be a great place to invest, grow and create jobs," said Wilson.

As part of the reforms the Ministers announced that the government would take immediate action to repeal much of the burdensome, job-killing red tape imposed by the previous government through the notorious Bill 148. These reforms include maintaining Ontario's current minimum wage

at $14 per hour until 2020, to be followed by increases tied to inflation. The government will also replace the previous government's disastrous Personal Emergency Leave rules. Instead, for the first time in Ontario's history, workers will be able to take up to three days for personal illness, two for bereavement and three for family responsibilities. Current provisions for domestic and sexual violence leave will be maintained, which is a valuable protection for employees. The proposed reforms will also reduce the red-tape burden around scheduling while updating the *Labour Relations Act.*

"Today's reforms are vital to create good jobs and stimulate new investment. We are lightening the burden on businesses and making sure that hard work is rewarded while proving to the world that Ontario is open for business," said Scott. "Businesses should have confidence in reasonable and predictable regulations. And everyone who works should have the confidence of a good job and a safe workplace."

The *Making Ontario Open for Business Act*, if passed, will also address the backlog in Ontario's skilled trades by replacing Ontario's outdated model with a one-to-one journeyperson-to-apprentice ratio for every trade for which ratios apply, thereby better aligning Ontario with other provinces and territories. The legislation, if passed, will also modernize the apprenticeship system by initiating an orderly wind-down of the Ontario College of Trades, which remains a source of unnecessary and burdensome complexity for skilled trades employment in the province.

"There are many tremendous and vibrant opportunities available in the skilled trades in Ontario. In fact, one in five new jobs in the next five years will be trades-related. But in Ontario today, employers can't find apprentices and apprentices can't find jobs," said Fullerton. "As far as we're concerned, if you are prepared to do the work then you deserve a shot at the job."

The government will continue to systematically review Ontario's stock of regulations, then streamline, modernize and, in some cases, eliminate unnecessarily complicated, outdated or duplicative regulations.

"Our government has been clear since day one - we are making Ontario open for business. It is time to bring quality jobs back to Ontario and help families get ahead. This legislation is just one way our government is working towards that goal," said Wilson.

ADDITIONAL RESOURCES

- Open for Business: Removing Burdens While Protecting Workers
- Open for Business: Modernizing Ontario's Apprenticeship System

CONTACTS

Sarah Letersky
Minister's Office
Sarah.Letersky@Ontario.ca

Ministry of Economic Development, Job Creation and Trade
https://www.ontario.ca/medjct

CIRCULATED WITH AGENDA

OF DEC 0 7 2018

COUNCIL ITEM# 9.1

College of Medical Radiation Technologists of Ontario

Ordre des technologues en radiation médicale de l'Ontario

Post Meeting Evaluations: Council Meeting, December 7, 2018

Please complete after the meeting and give to Linda Gough or Kirusha Kobindarajah

1 = Improvement Needed *(Please explain/suggest improvements in comments section)*
2 = Good/Okay
3 = Very Good

Information for Decision-making	**1**	**2**	**3**
a. The Council information package was received in a timely manner.			
b. Appropriate information was available in advance or at the meeting to support the Council in making informed decisions. Reports were clear and contained needed information.			
c. I had adequate opportunities to discuss the issues presented and ask questions.			
Effective Meetings	**1**	**2**	**3**
d. Agenda items were appropriate for Council discussion. Topics were relevant to the mandate and goals of CMRTO and identified as for information, discussion or decision.			
e. Time was used effectively; discussions were on topic.			
f. We avoided getting into administrative/ management details.			
g. Council members remained focused during the meeting -- avoiding sidebar conversations, responding to emails, etc.			
Directors fulfilling duty of care and diligence and instilling positive culture and values	**1**	**2**	**3**
h. All Council members seemed well-prepared for the meeting.			
i. There was a positive climate of trust, candour and respect.			
j. Council members participated responsibly -- exercising judgement and making decisions with a public interest and fiduciary perspective.			
k. Council members demonstrated the stated values of integrity, fairness, transparency, respect and professionalism			

COMMENTS

Please explain answers/ Make suggestions/ Offer observations:

I'd like more information concerning:

Name please_____

(Optional) Take-away or key learning from this meeting: