THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

CONFIRMATION OF STANDING BY MEDICAL LICENSING AUTHORITY

Completion of this form is required for the purpose of registration with the College of Physicians and Surgeons of Ontario (CPSO). The completed form must be returned directly to the CPSO by the medical licensing authority(ies) concerned. If necessary, please print additional copies.

The applicant is responsible to have the 3-page Confirmation of Standing by the Medical Licensing Authority form forwarded to the medical licensing authority in every jurisdiction where s/he practised medicine, postgraduate training appointments included. Note that an applicant for a Supervised Short Duration certificate of registration is required to arrange for confirmation of standing only from the medical licensing authority in the jurisdiction where s/he currently practices medicine.

For the purpose of registration with this College, the confirmation of standing from the jurisdiction where an applicant currently practices medicine remains valid for six (6) months from the date of issuance.

A certificate or letter of standing is acceptable in lieu of a completed Confirmation of Standing form only if the licensing authority will not complete the Confirmation form and only if the certificate or letter of standing attests to the same information as required in Part B of the Confirmation form.

PART A APPLICANT'S CONSENT TO RELEASE INFORMATION TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

To the Medical Licensing Authority in: _____
Name of Region / Province / State / Country

I am applying for a certificate of registration to practise medicine in the province of Ontario, Canada, and before my application can be assessed, information relating to my qualifications and medical practice activities in your jurisdiction is required.

I hereby authorize the release to the College of Physicians and Surgeons of Ontario of all information requested below and any further information which you deem relevant to my present application for a certificate of registration to practise medicine in Ontario, Canada.

I request the completed form and any additional information to be forwarded in an official sealed and stamped envelope or from the institutional email account noted on page 3 directly to:

Applications and Credentials Department
The College of Physicians and Surgeons of Ontario
80 College Street, Toronto, Ontario, Canada M5G 2E2
Email: credentials@cpso.on.ca

I understand you may require a fee for this service.

Print Full Name of Applicant: _____

Applicant's Licence Number in Jurisdiction Named Above: _____

Applicant's Address: _____

_____

Applicant's Signature: _____

Date: _____

PART B CONFIRMATION BY THE MEDICAL LICENSING AUTHORITY

1. This is to verify that,

a) Dr. _____
Full Name of Applicant Named in Part A

who graduated from _____
Full Name of Medical School

on _____,
Date of Graduation from Medical School

b) Has been issued the following licence(s) by this medical licensing authority:

Licence Number	Licence Type	Date Issued Month/Year	Date Expired Month/Year
		/	/
		/	/
		/	/
		/	/

c) Has the following specialty qualification(s) which is recognized by this medical licensing authority:

Specialty	Granted By	Date Issued Month/Year
		/
		/
		/

d) Undertook the following postgraduate training appointment(s) in the jurisdiction governed by this medical licensing authority (include internship, residency and fellowship training, as appropriate):

Type of Program	Hospital / University	From Month/Year	To Month/Year
		/	/
		/	/
		/	/

2. Has the above-named physician ever been the subject of an inquiry or an investigation by this licensing authority involving an allegation of professional misconduct, incompetence, incapacity or any like allegation?

Yes ☐ No ☐

3. Is the above-named physician currently the subject of an inquiry or investigation by this licensing authority involving an allegation of professional misconduct, incompetence, incapacity or any like allegation?

Yes ☐ No ☐

4. Does the above-named physician appear in the records of this licensing authority as having been subject to reduced, suspended or cancelled privileges by a hospital due to incompetence, negligence, incapacity or any form of professional misconduct?

Yes ☐ No ☐

5. Have there ever been any disciplinary or fitness to practise findings or any like findings, made by this licensing authority against the above-named physician?

Yes ☐ No ☐

For "Yes" response to questions 2, 3, 4 and/or 5, please provide all relevant information and supporting documents.

Print Name of the Medical Licensing Authority Official: _____

Title of the Medical Licensing Authority Official: _____

Original Signature of Medical Licensing Authority Official: _____

Date: _____

Full Name of the Medical Licensing Authority:

_____

_____

Mailing Address of the Medical Licensing Authority:

_____

_____

Email: _____

Telephone: _____

Fax: _____

Seal or Stamp of
the Medical Licensing Authority
to be Affixed Here

Rev: Jan/2017