

Dear Applicant:

The College is pleased to provide this application for an **Independent Practice** certificate of registration.

Note that this application package is for graduates of accredited medical schools in Canada or the United States of America.

The following are the current core requirements for an Independent Practice certificate of registration:

- Degree in medicine from an accredited medical school;
- Parts 1 and 2 of the Medical Council of Canada Qualifying Examination (MCCQE) or an acceptable alternative examination;
- Certification, by examination, by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC);
- Canadian citizenship or permanent resident status; and
- Completion of one year of clinical clerkship or postgraduate training at a Canadian medical school or one year of relevant active medical practice in Canada.

The College does not recognize any alternatives to these qualifications, except for those set out in the CPSO's various registration policies or under the provisions in the Ontario Regulated Health Professions Act relating to the Agreement on Internal Trade (AIT). For further details, please visit our website at www.cpso.on.ca, follow the Registration link from the home page.

This application package contains the following:

- Schedule of Requirements
- Information about the Certificate
- Application, Credentialing, and Payment Forms

For issuance of Independent Practice certificate of registration, you must complete all of the requirements set out in this schedule. This schedule requests a list of the minimum credentialing requirements. Following an initial assessment of your application, you may be required to provide additional information or arrange for third-party documents. For detailed information relating to registration process and timelines, you must review the **General Guidelines - Registration Process and Timelines** document available under Related Links on the Registration Applications and Forms page.

Should you have any questions, please contact the Applications and Credentials Department at (416) 967-2617, Monday to Friday 9:00 am to 5:00 pm EST.

The College looks forward to receiving your application, and wishes you a successful and rewarding practice in Ontario.

Sincerely,

Applications and Credentials Department

This schedule contains detailed information regarding the requirements for registration:

- PART A - The requirements to be returned by you
- PART B - The requirements you must arrange to be completed and returned by third parties

All requirements in this schedule must be completed. Please follow instructions carefully.

PART A:**REQUIREMENTS TO BE SENT BY APPLICANT****Application Form**

Your application form must be fully completed and the declaration on the last page must be signed. No action is taken on e-mailed forms.

Read the instructions and answer each question carefully. Every "yes" response in sections (a) – (g) must be explained in writing and supported by the required background documents or third-party reports.

In section (h), you will be required to report on exposure-prone procedures and blood-borne pathogens. For assistance with these questions, we strongly recommend that you review the CPSO policy on Blood Borne Viruses and FAQ. To access this material, select "Policies & Publications" on the top menu, "Policy" and select "Blood Borne Viruses" under the "Practice" drop-down menu.

Any missed questions or incorrect responses will require correction and may delay your application. Any conflicting or false responses will require written explanation.

Applications not completed after one year will be considered withdrawn.

Medical Degree

Photocopy of your medical degree from an accredited medical school in Canada or the United States of America.

For the purpose of application for a certificate of registration in Ontario, a graduate of an accredited medical school means a person holding an M.D. or equivalent degree in medicine that,

- (i) is from a medical school that is accredited by the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America, and
- (ii) is based upon successful completion of an undergraduate program of medical education that included a clerkship that complies with the regulation made under the Medicine Act, 1991.

Medical degrees issued in Latin language do not require translation.

Certification by Examination by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)

A legible photocopy of an official letter or certificate confirming that you hold certification by examination by the RCPSC or the CFPC.

If you recently passed the certification examination and have not yet received written confirmation of your certification, the College of Physicians and Surgeons of Ontario will be advised of your certification directly by the RCPSC or CFPC. This direct notice of certification is an established procedure among the Colleges that is efficient and reliable; nevertheless, should notice be delayed for any reason, it would be your responsibility to

follow up with the RCPSC or CFPC. Your certificate of registration cannot be issued until this notification is received.

Parts 1 and 2 of the Medical Council of Canada Qualifying Examination (MCCQE) or an Acceptable Alternative Examination

Legible photocopies of official letters from the Medical Council of Canada confirming that you have successfully completed Parts 1 and 2 of the MCCQE.

If you recently passed the MCCQE Part 2, note that the College will usually receive examination results directly from the MCC. Nevertheless, should this notice be delayed or incomplete, it would be your responsibility to follow up with the MCC.

Legible photocopies of official letters confirming that you successfully completed acceptable alternatives to Parts 1 and 2 of the MCCQE, as follows:

- (i) If completed successfully **before December 31, 1991**, the MCCQE (before the introduction of Parts 1 and 2), or
- (ii) If completed successfully **before December 31, 1991**, the examinations for the diploma of the National Board of Medical Examiners of the United States of America, or
- (iii) If obtained **before December 31, 1991**, a score of 75 on each of Component 1 and Component 2 of the Licensing Examination of the Federation of State Medical Boards of the United States of America (FLEX). If FLEX was taken before July 1, 1985, a weighted score average of 75 on all components is required.

Canadian Citizenship or Permanent Resident Status

One of the following is required:

- (i) Proof of valid Canadian citizenship (e.g. passport). Date of birth must be shown.
- (ii) Proof of valid Permanent Resident status under the Immigration and Refugee Protection Act (photocopy of both sides of your Permanent Resident card issued by Citizenship and Immigration Canada).

Report from the National Practitioner Data Bank (NPDB)

If you have practised medicine or taken postgraduate medical training in the United States, a “Self-Query” of NPDB is required.

You must submit to NPDB a Self-Query request for information disclosure, and then forward to the College the report you receive from NPDB. If you receive a rejection notice from NPDB, do not forward it to the College. Instead, re-submit your Self-Query to NPDB.

Note that the Self-Query must be submitted through the NPDB website. For further instructions and to start the Self-Query process, go to <http://www.npdb.hrsa.gov/>.

Disclosure of Criminal Record Information

You are required to arrange for a criminal record check using the Canadian Police Information Centre (CPIC) database, which can be obtained from a municipal or provincial police service in Canada. A vulnerable persons check is always acceptable. **Checks by third-party commercial vendors, including online vendors, are not accepted.**

Ensure your CPIC check covers:

- Current and all previous names;
- Convictions and current charges – both are required

- Correct date of birth

Please refer to the “Guide for Acceptable Criminal Record Checks” on the College’s website for additional assistance. Select the Registration menu at the top, followed by Registration Applications and Forms and access the document on the right side of the page.

Once obtained, please forward your criminal record check to the College. Do not wait for your check to submit with your application, as this will delay the processing of your file.

If your check indicates a possible match in the CPIC system, fingerprint verification from the Royal Canadian Mounted Police (RCMP) will be required to complete the screening process. You will be notified if this applies to you.

Note: For applicants residing outside of Canada, you must take into consideration the processing time of a minimum of 14 business days. Once processed, checks are valid 6 months from the date of issuance.

Curriculum Vitae

Your curriculum vitae must provide, at a minimum:

- (i) Undergraduate medical education information and date of graduation
- (ii) A listing, in chronological order (month/year) of all your postgraduate training appointments including, durations and level of training in every jurisdiction since graduation
- (iii) A listing, in chronological order (month/year) of all your professional appointments and type of practice including names of hospitals and/or clinics, discipline, duration and location (please specify the city, province/state, country)
- (iv) A listing of all your previous and current medical licences including type, duration, licence number and jurisdiction
- (v) A listing of specialist and other postgraduate examinations and qualifications

Any significant gaps in your training and practice history must be explained in the curriculum vitae.

Payment of Fees (\$2605.00)

Application Fee (non-refundable): \$980.00

Membership Fee: \$1625.00

Fees must be submitted with your application. No assessment of your application will be made until the application fee is received. The application fee is **non-refundable** regardless of whether your application is incomplete, withdrawn or refused.

Payment must be made using *Visa, American Express, MasterCard*, money order or certified cheque (payable to the College of Physicians and Surgeons of Ontario). Please use the form provided by the College to authorize payment of fees by *Visa, American Express or MasterCard*.

Personal cheques are not accepted.

Receipt of your payment of fees by the College does not confirm that you are eligible for registration nor does it confirm that your certificate of registration has been issued.

The application fee also includes Ontario Fairness Commissioner Registration Audit Recovery fee of \$5.

Fees are subject to change. Applications are subject to fee amounts in effect at time of submission.

PART B:**REQUIREMENTS TO BE SENT BY THIRD PARTY ORGANIZATIONS**

- C You must arrange for the documents below to be sent directly to the College by third party organizations.
- C Source documents sent by you will be rejected.
- C They must arrive by mail in an official, sealed and stamped envelope directly from the third party.
- C Courier delivery is acceptable, but the documents inside the courier package must be in an official envelope that has been sealed by the source organization. Courier packages must be sent directly to the College.

Medical School Transcript

Arrange for an official sealed transcript verifying your undergraduate medical education and conferral of degree in medicine.

If you attended more than one medical school, an official transcript will be required from each school. You must also arrange for a letter from the first school confirming that your transfer was voluntary and that you were in good standing at the time of transfer.

Inquiry Form for Board Action Search by the Federation of State Medical Boards

If you have practised medicine or taken postgraduate medical training in the United States, a board action search by the Federation of State Medical Boards of the United States is required.

You must complete an Inquiry Form: Federation of State Medical Boards Action Data Bank provided by the College and send it directly to the Federation of State Medical Boards at the address indicated in the form. The Federation will in turn send the Inquiry form directly to the College. You may send the form to boardinquiry@fsmb.org

Evidence of Standing

Using the “Confirmation of Standing” form provided by the College, you must provide evidence of good standing from the medical licensing authority **in every jurisdiction where you have practised medicine, or have taken postgraduate training.** If the form received does not cover your full period, a revised form will be required.

A certificate 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 of standing attests to the same information as required on the Confirmation form.

If you were **not required to hold a licence** to practise or train medicine in a jurisdiction, you must arrange for a letter from your Program Director or Supervisor. It must be sent directly to the College in an official, sealed and stamped envelope. It must confirm the dates of your appointment, type of position, satisfactory performance and conduct and that no registration or licensure was required.

For applicants who have trained in the United Kingdom, please ensure that the General Medical Council includes evidence of your Limited Registration. Copies of your Limited Registration certificates are also acceptable.

Reference Forms

Using the Reference Form provided by the College, please arrange for **three** references to be completed by the following individuals at the hospital where you presently practise: Chief of Staff; Department Head; Head Nurse.

If your current practice is not hospital-based, please arrange for three references from physicians in authority who can comment on your current practice, e.g. Medical Director or most senior physician at your clinic.

If you are currently enrolled in a clinical fellowship outside Ontario, one of three reference forms can be completed by your Program Director.

Instruct your referees to send their completed reference forms directly to the College.

Evidence of One Year of Training or Active Practice in Canada

*** Canadian graduates may skip this requirement

- (i) An official certificate, letter or training report signed by the program director confirming successful completion of at least one year of approved postgraduate training taken at an accredited medical school in Canada; or
- (ii) An official letter or certificate, signed by the executive director of a hospital or other health facility where you have held privileges confirming that you have successfully completed at least one year of active medical practice in Canada which includes significant clinical experience pertinent to your area of medical practice.

Graduates from the United States may skip this requirement only if they completed postgraduate training in Canada and the evidence of standing sent by the medical licensing authority confirms this information.

CANADIAN/US GRADUATES INDEPENDENT PRACTICE APPLICATION

INFORMATION ABOUT CERTIFICATE

Registration Committee Review

If your application presents any significant issues or deficiencies, review by the College's Registration Committee will be required. The Registration Committee meets once every four to six weeks, with a five week cut-off date preceding each meeting. Note that additional requirements may be requested and you will need to defer your start date.

Term, Condition and Limitation of the Independent Practice Certificate of Registration

Following completion of all requirements, the College will issue a certificate of registration authorizing independent practice. This certificate will carry the following standard term, condition and limitation:

You may practise only in the areas of medicine in which you are educated and experienced.

Any practice outside the physician's area of education and experience would contravene the term, condition and limitation of the Independent Practice certificate. If a physician intends to change scope of practice, he or she must follow the College's Change of Scope of Practice policy by participating in an individualized training and assessment process that will ensure safe and competent practice in the new area.

Fee for Service Billing Number

Eligibility for a fee-for-service billing number in Ontario is contingent on issuance of the certificate of registration. Billing numbers are issued by the Ontario Ministry of Health and Long-Term Care. For further information about obtaining an Ontario Health Insurance Plan (OHIP) number visit the Ministry's website at www.health.gov.on.ca.

Annual Renewal of the Certificate

Upon issuance of the certificate of registration, the applicant becomes a member of the College. To maintain the certificate, the member must renew membership each year through full payment of annual fee and completion of the mandatory renewal form. The College does not offer reduced membership fee for members on leave, residing put-of-province, or otherwise not using their certificate.

The College's membership year is June 1 to May 31. For new members registered partway through the membership year, the subsequent annual fee will be reduced by a pro-rated amount.

Should a member choose to resign from membership or allow the certificate to expire for failure to complete the annual renewal requirements, he or she cannot resume medical practice in Ontario without applying and qualifying for a new certificate of registration.

Credit Card Payment Authorization for Independent Practice Certificate Fees



THE COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

80 College Street,
Toronto, Ontario,
Canada
M5C 2E2
Toll free: (800) 268-7096

PLEASE NOTE: In order to comply with Payment Card Industry Data Security Standards, the College is not able to accept credit card payments by email or telephone. Faxed credit card payments will only be accepted if remitted directly to the Finance Department at (416) 967-2654.

For clarity, please complete this form electronically.

CPSO Number (or File#):	<input type="text"/>		
Applicant Given Name(s):	<input type="text"/>		
Applicant Surname:	<input type="text"/>		
Street Address:	<input type="text"/>	City:	<input type="text"/>
Province/State:	<input type="text"/>	Postal Code/Zip:	<input type="text"/>
		Country:	<input type="text"/>
Email Address:	<input type="text"/>	Phone Number:	<input type="text"/>

\$980.00 - Application Fee - Independent Practice
 \$1625.00 - Membership Fee - Independent Practice
 \$406.25 - Application Fee - Amendment to Modify Terms, Conditions, and Limitations (Restricted Class)
 \$330.00 - Application Fee - Short Duration

By selecting this fee, you acknowledge that you have read the Terms & Conditions with regard to a request for expedited initial assessment of your application. In doing so, you understand that an expedited review does not include the time taken to issue a certificate and that this service is not available for applications that require review by the College's Registration Committee.

\$490.00 - Expedited Assessment Fee - Independent Practice
 \$165.00 - Expedited Assessment Fee - Short Duration

I authorize The College of Physicians and Surgeons of Ontario to charge _____ to my:

Account Number

- - -

Expiry Date (MM/YY)

/

Cardholder Signature _____

Cardholder Name (Print)

Date



The College of

Physicians and Surgeons of Ontario

Applications and Credentials Department

80 College Street, Toronto, Ontario, Canada M5G 2E2

Telephone: 416-967-2617; 1-800-268-7096 (In Canada only)

APPLICATION FOR A CERTIFICATE OF REGISTRATION AUTHORIZING INDEPENDENT OR RESTRICTED PRACTICE

Mail or courier the original application to the College. Ensure there are no missing pages. No action is taken on faxed / emailed applications or applications received without a non-refundable application fee.



CPSO Registration or File Number _____

physiciansapply.ca Candidate Code _____

If applicable, before submitting this application, ensure to authorize sharing of medical degree credentials submitted to physiciansapply.ca for source verification through your profile on their website.

1. PERSONAL DETAILS

- a) One black and white or colour photograph must be affixed above. Photograph must be full face, of passport size and quality, and taken within six months of submitting this application.

The photograph of me attached hereto was taken on: _____ / _____ / _____
Day Month Year

b) _____
Last Name

_____ First Name Middle Names

- c) Have you ever been known by any other names? Yes No

If "Yes", provide your previous names: _____
Last Name

_____ First Name Middle Names

Evidence of name change must be submitted with application. Any discrepancy in how your name appears on the valid ID document submitted with application and the medical degree credentials must be explained.

d) Date of Birth: _____ / _____ / _____
Day Month Year

e) Gender: Male Female

f) Are you a Canadian Citizen? Yes No If not by birth, date granted: _____ / _____ / _____
Day Month Year

g) Do you hold Permanent Resident Status under the *Immigration and Refugee Protection Act (IRPA)*?

Yes No If "No", are you now applying for Permanent Resident Status under IRPA? Yes No

h) Do you hold an employment authorization (work permit) under the IRPA which enables you to engage in medical practice in Ontario?

Yes No

If "No", are you now applying for such an employment authorization under the IRPA?

Yes No

i) Have you previously applied for or been issued a licence or certificate of registration by the CPSO?

Yes No

If "Yes", please indicate your file number or certificate number in the space provided next to the photograph.

2. APPLICATION DETAILS

a) Please select if you are making an application for:

Independent Practice Certificate of Registration under Ontario Regulation 865/93: Registration, or

Restricted Certificate of Registration under one or more of the College's Registration Policies

If applying to the College's Registration Committee for a Restricted Certificate of Registration, please specify the Registration Policy you wish your application to be reviewed and processed under:

If applying for a Restricted Certificate of Registration, please confirm that you have identified a supervised practice arrangement in Ontario that meets the Guidelines for College-Directed Clinical Supervision:

Yes No If "No", please enclose an explanatory letter.

b) Anticipated Start Date for Medical Practice in Ontario: _____ / _____ / _____ Unknown
Day Month Year

3. CONTACT DETAILS

The mailing address you provide will be used as your official mailing address for communications from the College. The practice address you provide will be recorded in the College register and will be available to the public. Your mailing address will not be publicly available unless it is the same as your practice address. **As part of the application process, you may receive information pertaining to your application that is confidential. It is therefore your responsibility to ensure that your email address is secure.**

a) **Email Address:** _____

b) **Present Mailing Address:** _____

Telephone Number: (____) _____ - _____

c) **Present Primary Practice Address:** _____

Telephone Number: (____) _____ - _____

d) **Future Ontario Mailing Address:** _____

Effective Date: _____ / _____ / _____
Day Month Year

e) **Future Ontario Primary Practice Address:** _____

Effective Date: _____ / _____ / _____
Day Month Year

4. UNDERGRADUATE MEDICAL EDUCATION

a) Qualification Title of your Medical Degree:

b) Name and Address of University or School of Medicine granting your Medical Degree:

c) Date Granted: _____ / _____ / _____
Day Month Year

d) Period of time you were enrolled at this University or School of Medicine:

From: _____ / _____ To: _____ / _____
Month Year Month Year

e) Your native language is: _____

f) Language of instruction and/or language primarily used in patient care during the clinical parts of your education at the University or School of Medicine granting your Medical Degree:

English Yes No

French Yes No

Other Yes No

If you answered "Yes" to "Other", specify which language: _____

g) Before you graduated from the University or School of Medicine named above, did you attend any other University or School of Medicine to receive part of your medical education?

Yes No

If "Yes", please specify:

Name of University or School of Medicine	Location	From Month/Year	To Month/Year	Language of Instruction
_____	_____	/	/	_____
_____	_____	/	/	_____

h) If you obtained a degree of Doctor of Osteopathic Medicine, please confirm it was granted by an osteopathic medical school in the United States that was, at the time the degree was conferred, accredited by the American Osteopathic Association (AOA):

Yes No N/A Date Granted: _____ / _____ / _____
Day Month Year

i) Name and Address of University or School of Medicine granting your Doctor of Osteopathic Medicine Degree:

j) Period of time you were enrolled at this University or School of Medicine:

From: _____ / _____ To: _____ / _____
Month Year Month Year

5. POSTGRADUATE MEDICAL QUALIFICATIONS

a) Medical Council of Canada Examinations

Have you passed the Medical Council of Canada Evaluating Examination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
Have you passed, <u>prior to</u> December 31, 1991, the Medical Council of Canada Qualifying Examination (before introduction of MCCQE Part 1 and Part 2)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
Have you passed, <u>after</u> December 31, 1991, Part 1 of the Medical Council of Canada Qualifying Examination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
Have you passed, <u>after</u> December 31, 1991, Part 2 of the Medical Council of Canada Qualifying Examination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
If "No" have you registered to take Part 2 of the Medical Council of Canada Qualifying Examination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Expected Examination Date: _____ / _____ Month Year	

b) Equivalent to Medical Council of Canada Qualifying Examinations

Have you passed, <u>prior to</u> December 31, 1991, the examinations for the Diplomate of the National Board of Medical Examiners (NBME) of the United States of America?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
Have you obtained, <u>prior to</u> December 31, 1991, a score of seventy-five or better on each of Component 1 and Component 2 of FLEX – the Licensing Examination of the Federation of State Medical Boards of the United States of America?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	

c) Acceptable Alternative to Medical Council of Canada Qualifying Examinations

Have you passed the examinations for the Diplomate of the National Board of Medical Examiners (NBME) of the United States of America <u>between</u> January 1, 1992 and December 31, 1994?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
Have you obtained a score of seventy-five or better on each of Component 1 and Component 2 of FLEX – the Licensing Examination of the Federation of State Medical Boards of the United States of America <u>between</u> January 1, 1992 and December 31, 1994?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Examination Date: _____ / _____ Month Year	
Have you passed the United States Medical Licensing Examination (USMLE) Steps 1, 2 and 3? The Step 2 Clinical Skills (CS) is required if Step 2 was taken <u>after</u> June 12, 2004.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Step 1: _____ / _____ Step 2: _____ / _____ Step 3: _____ / _____ Month Year Month Year Month Year		
Have you obtained certification by the Educational Commission for Foreign Medical Graduates (ECFMG), based on United States Medical Licensing Examination (USMLE) Steps 1 and 2, plus USMLE Step 3? The USMLE Step 2 Clinical Skills Assessment (CSA) component is required if ECFMG certification was obtained <u>between</u> July 1, 1998, and June 14, 2004.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Certification Date: _____ / _____ Month Year	
Step 1: _____ / _____ Step 2: _____ / _____ Step 3: _____ / _____ Month Year Month Year Month Year		

Have you passed the Comprehensive Osteopathic Licensing Examination (COMLEX-USA) Levels 1, 2 and 3? COMLEX-USA Level 2 Performance Evaluation (PE) component is required if Level 2 was completed after September 2004.

Yes No

Step 1: ____ / ____ Step 2: ____ / ____ Step 3: ____ / ____
 Month Year Month Year Month Year

Have you passed the Examen Clinique Objectif Structuré (ECOS) of the Collège des Médecins du Québec between 1992 and 2000?

Yes No

Examination Date: ____ / ____
 Month Year

d) Royal College of Physicians and Surgeons of Canada Qualifications

Do you hold certification by examination by the Royal College of Physicians and Surgeons of Canada?

Yes No

Certification Date: ____ / ____
 Month Year

Specialty: _____

Yes No

Sub-specialty, if applicable: _____

Certification Date: ____ / ____
 Month Year

If "No", have you received an official assessment that you are eligible without preconditions to take the oral and the written examination of the Royal College of Physicians and Surgeons of Canada?

Yes No

Expected Examination Date:
 ____ / ____
 Month Year

Do you hold certification without examination by the Royal College of Physicians and Surgeons of Canada?

Yes No

Specify Route to Certification: _____

Certification Date: ____ / ____
 Month Year

Specialty: _____

e) College of Family Physicians of Canada Qualifications

Do you hold certification by examination in family medicine by the College of Family Physicians of Canada?

Yes No

Certification Date: ____ / ____
 Month Year

Do you hold certification by examination of special competence in emergency medicine by the College of Family Physicians of Canada?

Yes No

Certification Date: ____ / ____
 Month Year

If "No" have you received an official assessment that you are eligible without preconditions to take the College of Family Physicians of Canada examination in family medicine?

Yes No

Expected Examination Date:
 ____ / ____
 Month Year

Do you hold certification without examination by the College of Family Physicians of Canada?

Yes No

Specify Route to Certification: _____

Certification Date: ____ / ____
 Month Year

If "No", have you submitted an application for certification without examination?

Yes No

f) Collège des médecins du Québec Qualifications

Do you hold a specialist certificate, obtained by examination, by the Collège des médecins du Québec?

Yes No

Discipline: _____

Certification Date: _____ / _____
Month Year

If "No", specify route to certification: _____

g) Qualifications by the American Board of Medical Specialties

Do you hold certification by the American Board of Medical Specialties?

Yes No

Specialty: _____

Certification Date: _____ / _____
Month YearExpiry Date: _____ / _____
Month Year

Sub-specialty, if applicable: _____

Yes No Certification Date: _____ / _____
Month YearExpiry Date: _____ / _____
Month Year

If "No" have you received an official assessment that you are eligible to take the oral and the written examination of the American Boards?

Yes No Expected Examination Date: _____ / _____
Month Year**h) Other Qualifications**

Are you certified as a medical specialist by an organization outside Canada or United States that certifies medical specialists?

Yes No

Name of Organization Granting the Medical Specialist Qualification:

Certification Date: _____ / _____
Month Year

Discipline: _____

Are you certified as a medical sub-specialist by an organization outside Canada or United States that certifies medical specialists?

Yes No

Name of Organization Granting the medical sub-specialist qualification:

Certification Date: _____ / _____
Month Year

Discipline: _____

6. POSTGRADUATE MEDICAL TRAINING COMPLETED IN CANADA OR UNITED STATES

(a) Internship (If Applicable) and Residency Training Listed in Academic Years

Level	Discipline	Medical School	Base Hospital	From Month/Year	To Month/Year
INT				/	/
PGY1				/	/
PGY2				/	/
PGY3				/	/
PGY4				/	/
PGY5				/	/
PGY6				/	/
PGY7				/	/
				/	/

Was your training performance in all internship, elective and residency rotations to date rated as satisfactory by your Program Director? If "No", please attach a comprehensive explanation and identify the Program Director involved.

Yes
No

(b) Clinical and Clinical- Research Fellowships

Discipline	Medical School	Base Hospital	From Month/Year	To Month/Year
			/	/
			/	/
			/	/
			/	/

Was your training performance in all clinical or clinical-research fellowships to date rated as satisfactory by your Program Director? If "No", please attach a comprehensive explanation and identify the Program Director involved.

Yes
No

7. POSTGRADUATE MEDICAL TRAINING COMPLETED OUTSIDE CANADA OR UNITED STATES

a) Internship (If Applicable) and Residency Training Listed in Academic Years

Level	Discipline	Medical School	Base Hospital	From Month/Year	To Month/Year
				/	/
				/	/
				/	/
				/	/
				/	/
				/	/
				/	/
				/	/
				/	/
				/	/

Was your training performance in all internship, elective and residency rotations to date rated as satisfactory by your Program Director? If “No”, please attach a comprehensive explanation and identify the Program Director involved. Yes
No

b) Clinical and Clinical-Research Fellowships

Discipline	Medical School	Base Hospital	From Month/Year	To Month/Year
			/	/
			/	/
			/	/
			/	/

Was your training performance in all clinical or clinical-research fellowships to date rated as satisfactory by your Program Director? If “No”, please attach a comprehensive explanation and identify the Program Director involved. Yes
No

9. BREAKS IN MEDICAL TRAINING AND PRACTICE

Declare and account for all periods of six continuous months or more during which you did not practise medicine in any capacity either as a postgraduate clinical trainee or a clinical practitioner.

Be sure to include any delays occurring between the date of graduation from medical school and commencement of postgraduate training. Time spent in observerships / shadowing should also be declared.

Health-related research positions, including research fellowship(s) during which you did not maintain clinical patient contact constitute a break in medical training and practice history and must be listed.

Ensure dates provided are correct and complement the postgraduate training / practice history information provided in the application and the curriculum vitae. Missing periods or conflicting dates will require clarification.

Period		Reason for Break Explain why you took a break, e.g. parental leave, extended vacation, personal leave, immigration, observership / shadowing, research employment. Attach additional pages as necessary.
From Month/Year	To Month/Year	
/	/	
/	/	
/	/	
/	/	
/	/	
/	/	
/	/	

10. PROFESSIONALISM, CONDUCT, CHARACTER AND SUITABILITY TO PRACTISE MEDICINE

Each question must be answered carefully and honestly. Clarify any uncertainties with the College before you answer the questions. If you do not fully understand what a question means or how it should be answered, contact the College for assistance.

Any errors, discrepancies or omissions in your answers, no matter how minor, will delay your application and may require review by the College's Registration Committee.

Ensure that you consider any past practice in Ontario when responding to the questions and that your responses are consistent with those in any previous application you have made to the College.

For every "Yes" response, you must provide sufficient explanation and documentation. Without this, the College cannot proceed with your application. Later in the process, the College may ask you for further explanation or documentation.

If the events or circumstances behind any "Yes" response raise reasonable doubts about whether you fulfill the registration requirements, your application must be referred to the Registration Committee for review.

Be assured, however, that not every "Yes" response requires Registration Committee review, and that in either case your honest and frank disclosure will be appreciated by the College.

The College has a **non-exemptible requirement** for registration that the conduct of the applicant, including the applicant's past conduct, affords reasonable grounds for belief that the applicant:

- (i) is mentally competent to practise medicine,
- (ii) will practise medicine with decency, integrity and honesty and in accordance with the law,
- (iii) has sufficient knowledge, skill and judgment to engage in the medical practice authorized by the certificate, and
- (iv) can communicate effectively and will display an appropriately professional attitude.

Knowingly giving a false response to any question is grounds for refusal of the application by the Registration Committee and is an offence under s. 92 of the Ontario *Health Professions Procedural Code*.

a) APPLICATIONS TO MEDICAL LICENSING AUTHORITIES

In the following questions, "medical licence" includes any certificate of registration or permit to practise medicine of any type -- full, limited, temporary, provisional, training, etc.

- For every "Yes" response, provide a detailed explanation including all relevant names and dates.

(i) Have you ever applied anywhere for a medical licence and been refused?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Have you ever been refused renewal of your medical licence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Are you currently applying for a medical licence in any jurisdiction other than Ontario?	Yes <input type="checkbox"/> No <input type="checkbox"/>

b) ACTIONS BY MEDICAL LICENSING AUTHORITIES

In the following questions, "medical licensing authority" includes the College of Physicians and Surgeons of Ontario and any other licensing or regulatory authority that has had jurisdiction over your medical practice.

- For every "Yes" answer, provide a detailed explanation.
- For each complaint investigation outside Ontario, the College requires that you arrange for the medical licensing authority or other organization involved to forward all relevant information including, but not limited to, copies of the complaint, your formal response to the complaint, and the decision and reasons.

To facilitate this, the Consent to Release Information to the College of Physicians and Surgeons of Ontario form can be obtained by contacting Registration Inquiries at inquiries@cpsso.on.ca.

(i) Regardless of the outcome , have you ever been the subject of any complaint made to a medical licensing authority? <i>Be sure to disclose all complaints. Complaints that were dismissed, or closed with no further action, or otherwise resolved in any manner, must still be disclosed.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Are you currently the subject of any complaint made to a medical licensing authority?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Have you ever been the subject of any type of investigation, inquiry or proceeding by a medical licensing authority relating to your professional conduct, competence, capacity, or any other aspect of your medical practice? <i>Be sure to disclose all medical licensing authority investigations, inquiries or proceedings, including any audits or assessments of your practice.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Are you currently the subject of any type of investigation, inquiry or proceeding by a medical licensing authority relating to your professional conduct, competence, capacity, or any other aspect of your medical practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Have you ever had a medical licence revoked, suspended, restricted, limited, or subjected to any other adverse action?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vi) Have you ever voluntarily entered into an undertaking or agreement, or voluntarily restricted, resigned or surrendered your medical licence, either during or subsequent to an inquiry, investigation or proceeding relating to your professional conduct, competence, capacity, or to any other aspect of your medical practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vii) Have you ever been required to enter into an undertaking or agreement, or been required to restrict, resign or surrender your medical licence, either during or subsequent to an inquiry, investigation or proceeding relating to your professional conduct, competence, capacity, or to any other aspect of your medical practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>

c) LEGAL ACTIONS, SETTLEMENTS AND COURT FINDINGS

- *For each action or claim, provide an explanation of the events that led to the action, the patient's condition at the point of your involvement, the nature and extent of your involvement, and the degree of your responsibility for the patient's care. Also, provide copies of the statement of claim or complaint, statement of defence or response, court judgment or court order, and settlement agreement. If the supporting documents are not in your possession, please contact the Canadian Medical Protective Association (CMPA) or your legal counsel to authorize release to the College.*
- *For past actions in Canada, contact a Medical Officer at the CMPA and authorize a report to be sent directly to the College that describes the action, your role in the events, and the outcome of the action. A report from your legal counsel will be required if the CMPA does not confirm the necessary details of the action.*
- *For current actions in Canada, contact your legal counsel and request a report to be sent directly to the College that describes the action, your role in the events, and the present status of the action.*
- *For actions outside Canada, contact your legal counsel or insurance carrier and request a report to be sent directly to the College that describes the action, your role in the events and the outcome or present status of the action.*

(i) Has there ever been any civil proceeding, legal action, insurance or other claim that was in any way related to your practice of medicine or your professional activities?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Is there currently any civil proceeding, legal action, insurance or other claim that is in any way related to your practice of medicine or your professional activities?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Have you ever agreed to a settlement or other resolution to avoid or resolve any civil proceeding, legal action or claim that was in any way related to your practice of medicine or your professional activities?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Has a court ever made a finding against you in respect of a civil proceeding, legal action or claim that was in any way related to your practice of medicine or professional activities?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Have you ever been denied professional liability protection or insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>

d) CHARGES AND CONVICTIONS

In the following questions, “offence” includes driving offences such as impaired driving, dangerous driving, driving while suspended, refusing to give a breath or blood sample, or failing to stop at the scene of an accident – **these are all major offences which must be disclosed**. You need not disclose minor traffic offences, such as parking violations.

- For every “Yes” response, provide a detailed explanation and include copies of relevant documents, e.g. conviction, indictment or summons forms; conditional or absolute discharge orders; other court orders and records.
- If you have been granted a pardon for a past conviction, enclose a copy of the pardon document.

(i) Have you ever pleaded guilty to, or been found guilty of, any offence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Have you ever pleaded no contest or made any similar plea to any charge?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Are there any charges now pending against you for any offence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Have you ever been charged or arrested for any offence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Have you ever entered a diversion program or other resolution process as an alternative to conviction or prosecution for an offence?	Yes <input type="checkbox"/> No <input type="checkbox"/>

e) PRIVILEGES AND PROFESSIONAL EMPLOYMENT

- For every “Yes” response, provide a detailed explanation including all relevant names and dates.
- Arrange for the chief of staff, department head, executive officer, or employer to send directly to the College a report setting out the circumstances and reasons behind the action.

(i) Have you ever been denied privileges or been denied appointment or reappointment to the medical staff of a hospital or other health facility?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Have you ever withdrawn an application for privileges at a hospital or other health facility?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Have you ever voluntarily relinquished or changed your privileges or resigned from a hospital, health facility, or any other place of employment either during, subsequent to or in expectation of, an inquiry, investigation or review that was in any way related to your professional conduct, competence, capacity, or any other aspect of your medical practice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Have your privileges ever been revoked, suspended, cancelled, reduced or otherwise changed by a hospital or other health facility?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Have your privileges or legal authority to purchase, prescribe, possess or dispense narcotic, controlled or designated drugs ever been restricted, reduced, withdrawn or surrendered?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vi) Are you now or have you ever been the subject of any type of investigation, inquiry, review or action by a hospital, health facility, or any other place of employment relating to your professional conduct, competence, capacity, or any aspect of your medical practice? <i>Be sure to disclose all such matters, <u>regardless of outcome</u>.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

f) MEDICAL EDUCATION AND ACADEMIC CONDUCT

- For every “Yes” response, provide a detailed explanation including all relevant names and dates.
- If the matter is under appeal or has been successfully completed / remediated you must still answer “Yes”.
- For “Yes” responses, arrange for the undergraduate dean or the postgraduate dean or program director to send directly to the College a letter setting out the circumstances and reasons behind the matter.

Undergraduate Medical Education

(i) Have you ever withdrawn from, or been expelled or suspended by a medical school?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Have you ever been put on probation or remediation by a medical school?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Have you ever taken a leave of absence of six months or longer from a medical school or otherwise interrupted your undergraduate medical education for six months or longer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Have you ever transferred from one undergraduate medical education program to another?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Have you ever been the subject of any type of investigation, inquiry or proceeding relating to misconduct of any type during your undergraduate medical education?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vi) Has your enrollment in medical school been prolonged or extended for any reason beyond the standard curriculum completion time set by your medical school?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Postgraduate Medical Education

(vii) Have you ever been dismissed, suspended or removed from a postgraduate medical training program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(viii) Have you ever been put on probation or remediation during a postgraduate medical training program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ix) Have you ever taken a leave of absence of six months or longer from or otherwise interrupted a postgraduate medical training program for six months or longer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(x) Have you ever transferred from one postgraduate training program to another without having fully completed the first program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(xi) Have you ever withdrawn or resigned from a postgraduate medical training program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(xii) Have you ever been the subject of any type of investigation, inquiry or proceeding relating to misconduct of any type during your postgraduate medical education?	Yes <input type="checkbox"/> No <input type="checkbox"/>

General

(xiii) Have you ever been investigated or sanctioned by any academic, research or medical educational body of any type for any violation of academic policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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g) MEDICAL CONDITIONS (GENERAL)

In the following questions, "medical condition" refers to any physical or mental disorder or illness.

- For every "Yes" response, provide a detailed explanation and arrange for your treating physician(s) to send directly to the College a report on your medical condition setting out your diagnosis, course of treatment, current health and prognosis.

(i) Do you currently have any medical condition that affects or could affect your ability to practise medicine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Have you ever had any medical condition that has affected or could affect your ability to practise medicine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Have you ever taken a medical leave of absence, <u>of any duration</u> , from a medical school, a postgraduate medical training program or any professional position or employment? <i>Please take note that all medical leaves of absence must be disclosed, even those less than six months in duration.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Are you now abusing, dependent on, or addicted to alcohol or a drug?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Are you being treated for abuse of, dependence on, or addiction to alcohol or a drug?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vi) Have you ever abused, been dependent on, or addicted to alcohol or a drug?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vii) Have you ever been treated for abuse of, dependence on, or addiction to alcohol or a drug?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(viii) Do you now have a communicable disease or are you a carrier, whether asymptomatic or otherwise of an infectious agent of a communicable disease, i.e. latent TB?	Yes <input type="checkbox"/> No <input type="checkbox"/>

h) MEDICAL CONDITIONS (BLOOD BORNE VIRUSES)

- For every response in bold, provide a detailed explanation. Once your application is assessed, the College will follow up with you regarding your responses and advise you of further requirements.

(i) In your current practice either in Ontario or another jurisdiction do you, or will you, once you are registered with the College, 1. perform, assist in performing, or have the potential to perform or assist in performing exposure-prone procedures (e.g. emergency physicians) as defined in the Blood Borne Viruses policy? OR 2. perform or assist in performing procedures that may become exposure-prone (e.g. a laparoscopic that may convert to an open procedure)? If "Yes" to either (1) or (2), answer questions (ii) to (v). If "No" to (1) and (2), skip questions (ii) to (vii).	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Have you had your blood tested for Hepatitis C and HIV in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Are you infected with and/or have you had a positive blood test with respect to Hepatitis C or HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iv) Have you been vaccinated against Hepatitis B virus?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(v) Have you had post-vaccination testing that confirms immunity to Hepatitis B virus? If "No", answer (vi) and (vii).	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vi) Have you had your blood tested for Hepatitis B virus in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(vii) Are you infected with or have you had a positive blood test with respect to Hepatitis B virus? If you test positive for the surface antibodies only, answer "No".	Yes <input type="checkbox"/> No <input type="checkbox"/>

i) GENERAL

- For every “Yes” response, provide a detailed explanation.

(i) Have you ever ceased, interrupted or delayed commencement of postgraduate training or medical practice for any reason for six months or longer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(ii) Are you now subject to any contract, agreement, undertaking or obligation with any medical licensing authority, health facility or other regulatory or governmental body that might be an impediment to your application for a certificate of registration to practise medicine in the province of Ontario?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(iii) Is there any event, circumstance, condition or matter not disclosed in your answers to the preceding questions in respect of your character, conduct, competence or capacity that might be relevant to your application for a certificate of registration to practise medicine in the province of Ontario?	Yes <input type="checkbox"/> No <input type="checkbox"/>

j) UNDERSTANDING, AGREEMENT and THIRD-PARTY AUTHORIZATION

- 1) I understand that I will be deemed by the College of Physicians and Surgeons of Ontario (the “College”) not to have satisfied the requirements and qualifications for a certificate of registration if, in connection with this application or any past application, I have made a false or misleading representation, either because of what was stated or left unstated.
- 2) I understand that any certificate of registration that results from this application is void and is deemed to have always been void if I have made any false or misleading representation or declaration on or in connection with this application, whether by commission or omission.
- 3) I agree that during the course of this application I will immediately notify the College in writing of anything that renders any response to the questions in this application, although true and complete when made, no longer true and complete. I understand that failure to notify the College of any such thing may void any certificate of registration that results from this application.
- 4) I understand that the College's registration and credentialing requirements are subject to change and that any such changes, including possible updates during the course of this application may apply to me. I understand that the maximum term of validity for most supporting source credentialing documents is six months from the date of issuance. I understand that if my application remains incomplete or inactive for one year, it will be considered withdrawn.
- 5) I understand that the submission of this application for registration to the College and any registration with the College that may result, shall constitute and operate as authorization by me for the College to make such inquiries about me of any kind that it considers appropriate in connection with this application and to disclose information about me to other medical licensing authorities, federations of licensing authorities, hospitals and other institutions to which I apply for appointment.
- 6) I understand that this Understanding, Agreement and Third-party Authorization is valid commencing on the date subscribed below and that this Understanding, Agreement and Third-party Authorization will remain in force and effect during the course of this application and until I no longer hold a certificate of registration issued by the College.

Print Full Name of Applicant

Signature of Applicant

Date: ____/____/____
Day Month Year

11. PROFESSIONAL LIABILITY PROTECTION

Under the College's registration regulation, applicants for registration must hold professional liability protection in compliance with the College's by-laws, as follows:

Each member shall obtain and maintain professional liability protection that extends to all areas of the member's practice, through one or more of,

- (a) *Membership in the Canadian Medical Protective Association;*
- (b) *A policy of professional liability insurance issued by a company licensed to carry on business in Ontario that provides coverage of at least \$10,000,000;*
- (c) *Coverage under the Treasury Board Policy on Legal Assistance and Indemnification (for Crown servants of Canada).*

Dependent on your circumstance, please complete either the Declaration OR the Undertaking section.

a) Professional Liability Protection – Declaration by Applicant

Not Applicable

I, _____, hereby declare to the College of Physicians and Surgeons of Ontario ("the College") as follows:

1. I currently hold professional liability protection that extends to all areas of my practice in Ontario. My professional liability protection is provided through:
 - (a) Membership in the Canadian Medical Protective Association (CMPA), under membership number: _____, or
CMPA # _____
 - (b) A policy of professional liability insurance issued by a company licensed to carry on business in Ontario that provides coverage of at least \$10,000,000, namely _____, or
Name of Company _____ Policy Number _____
 - (c) Coverage under the Treasury Board Policy on Legal Assistance and Indemnification (for Crown servants of Canada).
2. I understand that after I am registered with the College and have identified the provider of my professional liability protection, the College may inquire with the provider regarding whether I hold professional liability protection in compliance with s. 50.2 of the College by-law, and I hereby consent to disclosure of this information to the College by the provider of my professional liability protection.
3. I understand that I must have available in my office, in written or electronic form, for inspection by the College, evidence that I hold professional liability protection.
4. I understand that my registration with the College will expire when I no longer hold professional liability protection.
5. I understand that before each annual renewal of my College registration, I must sign a declaration that I hold professional liability protection.
6. I understand that it is an offence under s. 92 of the *Health Professions Procedural Code* to make a false representation for the purpose of having a certificate of registration issued.
7. I understand that I will be deemed not to have satisfied the requirements and qualifications for a certificate of registration if I have made a false or misleading representation in this Declaration.

Print Full Name of Applicant

Signature of Applicant

Date: _____/_____/_____
 Day Month Year

b) Professional Liability Protection – Undertaking by ApplicantNot Applicable

I, _____, hereby undertake, agree, and consent to the College of Physicians and Surgeons of Ontario (“the College”) as follows:

1. Before I provide any medical service in Ontario to any person, I will obtain professional liability protection that complies with s. 50.2 of the College by-law. Specifically, my professional liability protection will extend to all areas of my practice and be provided through one or more of,
 - a) membership in the Canadian Medical Protective Association (CMPA);
 - b) a policy of professional liability insurance issued by a company licensed to carry on business in Ontario that provides coverage of at least \$10,000,000.
 - c) coverage under the Treasury Board Policy on Legal Assistance and Indemnification (for Crown servants of Canada).
2. Within thirty (30) days of obtaining such professional liability protection, I will sign and submit to the College a declaration to that effect, using the College form “Declaration by Member: Professional Liability Protection.”
3. I understand that after I am registered with the College and have identified the provider of my professional liability protection, the College may inquire with the provider regarding whether I have professional liability protection, and I hereby consent to disclosure of this information to the College by the provider of my professional liability protection.
4. I understand that I must have available in my office, in written or electronic form, for inspection by the College, evidence that I hold professional liability protection.
5. I understand that my registration with the College will expire when I no longer hold professional liability protection.
6. I understand that before each annual renewal of my College registration, I must sign a declaration that I hold professional liability protection.
7. I understand that a breach of this undertaking is an act of professional misconduct which may result in referral of a specified allegation against me of professional misconduct to the Discipline Committee of the College.

Print Full Name of Applicant

Signature of Applicant

Date: _____/_____/_____
 Day Month Year

12. CONSENT FOR RELEASE OF INFORMATION: MEDICAL INFORMATION NUMBER OF CANADA

For the purpose of generating the Medical Information Number of Canada (MINC) number that will be permanently assigned to you or for checking the existing MINC number, completion of this part of consent section is required. Please read the details about the MINC system and answer the question below.

Not Applicable - Consent provided with the previous application made to this College.

A not-for-profit corporation, Medical Identification Number for Canada, known as “MINC#NIMC”, has been incorporated by the Federation of Medical Regulatory Authorities of Canada (FMRAC) and the Medical Council of Canada (MCC) for the sole purpose of administering the MINC number system.

This number will be issued to all health care professionals who consent in writing. Once assigned, an individual’s MINC number will remain unchanged throughout his/her entire medical career. Assigned numbers are never reused and individuals will carry the same number even if they leave Canada and return, move between jurisdictions or change registration status.

The only information encoded in an individual’s MINC is a country code (CA for Canada) and a profession code (MD for Medicine). The MINC number does not imply any special privilege, rights or status; it is simply a series of letters and numbers for identification purposes.

When you consent, the College of Physicians and Surgeons of Ontario will submit your personal information to MINC#NIMC as follows: name(s) (and previous name(s) if applicable), gender, date of birth, country of birth and year and university of graduation, collectively referred to as the “Core Information”.

MINC#NIMC will use Core Information to either generate or confirm an existing MINC and will retain the Core Information and its associated MINC in its system for the purposes of identifying individuals and ongoing identity confirmation by Prime and Licensed Users of the MINC system.

“Prime Users” are those organizations that are authorized to request issuance of a MINC (the MCC and the twelve Canadian medical regulatory authorities). “Licensed Users” are those organizations that have contracted with MINC#NIMC to use these numbers.

Not-for-profit and public sector organizations that are involved in the education, certification, licensure or professional practices of physicians in Canada may apply to MINC#NIMC for a license to use the MINC system as a means of:

- (i) Accurately identifying individuals with whom they have dealings,
- (ii) Processing information relating to those individuals, and
- (iii) Linking or exchanging physician information with other Licensed or Primary Users for Approved

Purposes such as the compilation of statistics, the development of profiles, the administration of programs or benefits, the management of the health system and research.

Licensed Users agree to comply with MINC#NIMC’s Privacy Code, with privacy, security and confidentiality provisions, and with applicable privacy legislation as part of their licensing agreements. The only information that shall be disclosed to Licensed Users shall be the medical identification numbers for their own members. Prime Users will have controlled access to both the MINC number and Core Information to facilitate the performance of their regulatory responsibilities.

For a more complete description of MINC#NIMC, including its Privacy Code and a complete list of all Prime and Licensed Users and their approved uses, consult the MINC#NIMC website at www.minc-nimc.ca.

Consent for Release of Information to the Medical Information Number of Canada

I have read and understand the above information, and consent to the College of Physicians and Surgeons of Ontario’s release of the Core Information to MINC#NIMC for the purpose of generating a MINC number that will be permanently assigned to me or checking my existing Core Information with MINC#NIMC.

Yes

I further consent to MINC#NIMC storing the MINC number in its database and disclosing the MINC number to Prime and Licensed Users, as outlined above. I also understand that I may withdraw my consent to MINC at any time, by written notice to MINC#NIMC.

No

Print Full Name of Applicant

Signature of Applicant

Date: ____/____/____
Day Month Year

13. DECLARATION

Subsections 92 (1) (a) and 92 (2) (a) of the *Health Professions Procedural Code* state:

92 (1) (a) *Every person who makes a representation, knowing it to be false, for the purpose of having a certificate of registration issued is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 and not more than \$50,000 for a second or subsequent offence;*

92 (2) (a) *Every person who knowingly assists a person in committing an offence under subsection (1) is guilty of an offence and on conviction is liable in the case of an individual, to a fine of not more than \$25,000 and not more than \$50,000 for a second or subsequent offence.*

I, Dr. _____
Full Name of Applicant

of the _____ of _____
Type of Municipality (City, Town or County) Name of Municipality (City, Town or County)

in the _____ of _____
Province, State or Country Name of Province, State or Country

hereby declare the following:

- 1) I am the person making the application for a certificate of registration to practice medicine in the Province of Ontario.
- 2) The photograph attached to the first page of the application is an unaltered photograph of me taken within six months before the application is made.
- 3) I have, read, understood and signed the application to which this declaration is attached.
- 4) The answers I have given to the questions in the application to which this declaration is attached are true, complete and without intent to mislead.
- 5) I understand that I am not permitted to engage in any kind of medical practice in Ontario until I have actually been issued a certificate of registration authorizing such practice.
- 6) If the College of Physicians and Surgeons of Ontario issues a certificate of registration to me, I promise to comply with the regulations and by-laws of the College.
- 7) I make this declaration conscientiously believing it to be true, and knowing that it is of the same force and effect as if made under oath and by virtue of the *Canada Evidence Act*.

Print Full Name of Applicant

Signature of Applicant

Date: ____/____/____
Day Month Year



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: _____

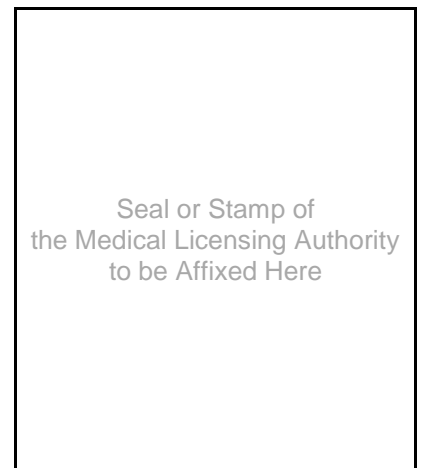
Full Name of the Medical Licensing Authority:

Mailing Address of the Medical Licensing Authority:

Email: _____

Telephone: _____

Fax: _____



Rev: Jan/2017



LIST OF REFEREES

Please list below the names of referees to whom you have sent the College's Reference Form for completion and return the completed list with your application. This list will assist the College in the efficient credentialing of your application.

Note that the evaluation of an individual who is presently in a position of formal authority over your work should be based on demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience and professional background as yours.

A minimum of three references is required. That is, from the Program Director, Chief of Staff, Department and/or Division Head, Senior Colleague, Medical Director or Nurse at your current place of employment. Additional references may be required in certain cases, i.e. if you have a current secondary practice.

If you have practised for less than six months at your current place of employment, arrange for a reference from the previous employer.

If your present practice is office-based, arrange for references from individuals in authority who can best comment on your current practice, e.g. most senior physician at your clinic, physician who covers for you in your absence, physician whom you refer patients to or receive referrals from on a regular basis.

Updated references are required should your application remain in process for longer than 6 months.

Applicant's Full Name: _____ Date: _____

Referee 1: Name _____

Position _____

Facility Name _____

Location (City, Province/State, Country) _____

Referee 2: Name _____

Position _____

Facility Name _____

Location (City, Province/State, Country) _____

Referee 3: Name _____

Position _____

Facility Name _____

Location (City, Province/State, Country) _____

Referee 4: Name _____

(If Applicable)

Position _____

Facility Name _____

Location (City, Province/State, Country) _____



REFERENCE FORM

This evaluation should be based on demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience and professional background as the applicant. Please complete all parts of this form.

Full Name of Applicant: _____

CPSO File # (if known): _____

Section 1: REFEREE INFORMATION

Full Name: _____

Primary Site of Practice: _____

Current Position / Title: _____

a) Is the applicant related to you? † Yes ____ No ____

b) Do you work in the same location as applicant? Yes ____ No ____

c) In what capacity do you currently work with the applicant?

Program Director ____ Chief of Staff ____ Department/Division Head ____

Senior Colleague ____ Medical Director ____ Nurse ____

d) Are you presently in a position of formal authority over the applicant's work? † Yes ____ No ____

If No, please explain: _____

e) How long have you worked with the applicant? From ____ / ____ To ____ / ____
Month / Year Month / Year

f) Name of hospital/clinic/university where you presently work with the applicant? _____

Section 2: APPLICANT INFORMATION

Description of the applicant's medical activities:

In your experience working with the applicant, please rate the applicant in the following competencies with any concerns related to the applicant noted in section H:

a) Medical Expert

	Above Average	Average	Below Average	Unknown
Basic scientific knowledge				
Basic clinical knowledge				
History and physical examination				
Orders test appropriately				
Interpretation and utilization of information				
Clinical judgment and decision making				
Technical skills required in the specialty				
Overall performance				

b) Communicator

	Above Average	Average	Below Average	Unknown
Interprofessional relationships with physicians				
Communication with other allied health professionals				
Communication with patients				
Communication with families				
Written communication & documentation				

c) Collaborator

	Above Average	Average	Below Average	Unknown
Asks for referrals appropriately to physicians and non-physicians				
Interacts and consults effectively with health professionals by recognizing and acknowledging their roles and expertise				
Delegates effectively				

d) Leader

	Above Average	Average	Below Average	Unknown
Understands and uses information technology				
Uses health care resources cost-effectively				
Organization of work and time management				

e) Health Advocate

	Above Average	Average	Below Average	Unknown
Advocates for the patient				
Advocates for the community				

f) Scholar

	Above Average	Average	Below Average	Unknown
Motivation to read and acquire knowledge				
Critically appraises medical literature				
Teaching skills				
Completion of research/project				

g) Professional

	Above Average	Average	Below Average	Unknown
Integrity and honesty				
Sensitivity and respect for diversity				
Responsibility and self-discipline				
Communicates with patients with compassion and empathy				
Recognition of own limitations, seeking advice when needed				
Understands principles of ethics: applies to clinical situations				
Understands boundary issues/ethical limits				

h) Strengths and Areas of Improvement

What are the applicant's greatest strengths?

What areas of improvement and development have been identified for the applicant?

i) Other

Do you have any additional information with respect to this applicant which may be relevant to his/her application for registration to practice medicine in Ontario?

Section 3: SUMMARY RECOMMENDATION

RECOMMEND WITHOUT RESERVATIONS

RECOMMEND WITH RESERVATIONS

DO NOT RECOMMEND

If recommending with reservations or do not recommend, please explain:

Please email / call me to discuss this applicant Yes ____ No ____

E-mail: _____ ↑

Phone number: (____) _____ - _____

Best time to call: _____

Full Name: _____

Title: _____

Signature: _____

Date: _____ / _____ / _____

Reference forms sent by the applicant are not acceptable. The referee must return the completed form directly to the College:

1. Scanned copy by email to credentials@cpso.on.ca, or
2. By mail, in an official or stamped envelope to:

The College of Physicians and Surgeons of Ontario
Applications and Credentials Department
80 College Street, Toronto, Ontario M5G 2E2

Thank you for taking the time to complete the reference form. If you have any questions, please contact Registration Inquiries at (416) 967-2617, Monday through Friday 9am to 5pm (EST).

INQUIRY FORM: FEDERATION OF STATE MEDICAL BOARDS ACTION DATA BANK

TO APPLICANT:

Please complete and forward this form directly to the Federation of State Medical Boards by e-mail to boardinquiry@fsmb.org. All search results are returned to the designated board electronically.

TO THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES:

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 is required. I hereby authorize your releasing to the College of Physicians and Surgeons of Ontario the results of your search for information about me in the Board Action Data Bank.

I request a summary report(s) and any appended information to be forwarded directly to:

The College of Physicians and Surgeons of Ontario
Applications and Credentials Department
80 College Street, Toronto, Ontario, Canada M5G 2E2

My personal details are as follows:

Name: _____
Last Name

_____ First Name Middle Name

Date of Birth: ____ / ____ / ____
Day Month Year

_____ Medical School (Include complete name and, if applicable, branch location)

_____ Degree Year of Graduation Country of Medical School

_____ ECFMG Number (for foreign medical graduates) USA Social Security Number (if applicable)

_____ Physician's Signature

_____ Date