



The College of
Physicians and Surgeons of Ontario

**APPLICATION FOR REGISTRATION:
INDEPENDENT PRACTICE – ONTARIO FINAL-YEAR RESIDENTS**

Dear Applicant:

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

Note that this application package is to be used only by residents in their final year of residency at an Ontario medical school.

This schedule assumes that you will be taking the spring 2018 examinations of the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC) and/or, if applicable the Medical Council of Canada Qualifying Examination (MCCQE) Part 2.

This application package contains the following:

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

If you have a July 1 start date, we strongly encourage you to submit your complete application package by May 18, 2018 to allow sufficient processing time. Applications received after May 18, 2018 may not be processed in time for a July 1, 2018 start date. Do not wait for your examination results before applying to the College.

Do not commit to a start date for your practice until your Independent Practice certificate has been issued.

For detailed information relating to registration process and timelines, you must review the General Guidelines document available on our website. Select *Applicant Information* on the homepage, followed by *Registration Applications and Forms*.

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 experience 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.

Should the assessment of your application and/or supporting documents reveal any omissions, deficiencies or that completion of additional credentialing items is required, you will be notified. Please ensure to regularly check the status of your application online.

Additional credentialing documents and updates will be required should your application remain incomplete for any reason, for more than one month following the expiry of your Postgraduate Education certificate.

If your application presents any significant issues, review by the Registration Committee will be required. The Registration Committee meets once every four to six weeks, with a 5 week cut-off date preceding each meeting. You will be notified which documents, in addition to those outlined in this schedule, are required for referral to Registration Committee. You will need to defer your starting date for practice.

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 faxed / emailed applications or applications received without a non-refundable application fee.

In the section relating to “Professionalism, Conduct, Character and Suitability to Practise Medicine”, ensure that you read the instructions and answer each question carefully. Every “Yes” response must be explained in writing and supported by the required background documents or third-party reports. Any conflicting or false responses will require written explanation.

In this application you are also 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 the FAQ document posted on our website.

Applications not completed after one year will be considered withdrawn.

Medical Degree

Provide a legible photocopy of Canadian medical degree. This requirement does not apply to graduates from medical schools outside Canada, as all such graduates were required to complete this requirement as part of their application for Postgraduate Education.

Evidence of Canadian Citizenship or Permanent Resident Status

One of the following is required:

- Photocopy of valid Canadian passport clearly showing your full name, date of birth and date of expiry.
- Photocopy of both sides of valid Permanent Resident card issued by Citizenship and Immigration Canada.

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, and checks obtained from a service agency outside Canada are not accepted.

Ensure your criminal record 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 posted on the College’s website for additional assistance. Select *Applicant Information* from the homepage, followed by *Registration Applications and Forms*.

Do not wait for the criminal record check to submit your application. Once obtained, please forward all pages of your criminal record check to the College.

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.

You must take into consideration the Canadian criminal record check processing time of a minimum of 14 business days. The results of a criminal record check remain valid for 6 months from the date of issuance. The check must also be valid when your Certificate of Registration is issued by the CPSO.

Payment of Fees

| | | AS OF JUNE 1 st , 2018 |
|--------------------------------------|-----------|-----------------------------------|
| Application Fee (non-refundable): | \$980.00 | \$1040.00 |
| Membership Fee: | \$1625.00 | \$1725.00 |
| Expedited Assessment Fee (optional): | \$487.50 | \$517.50 |

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.

Initial assessment for eligible applicants who choose to pay the expedited assessment fee will occur in less than three weeks. Expedited review is not available for applications that must be reviewed by the Registration Committee. You will be notified if this applies to you.

If your application is received after the May 18th deadline, we strongly suggest that you submit the expedited assessment fee to ensure completion of initial assessment before July 1st.

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

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

If you pass the spring 2018 RCPSC or CFPC certification examinations, the College will be automatically notified of your certification directly by the RCPSC or CFPC. Notice will be sent as quickly as permitted by RCPSC and CFPC by-laws (mid to late June). 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.

CFPC Trainees

If you intend to begin practice on July 1 and have not received email confirmation in late June that your certificate has been issued, check the College's website. Enter your registration number in the "Find a Doctor" section. You may start independent practice only if "Independent Practice" appears in the Registration Class field. You may also call the Applications and Credentials Department at (416) 967-2617 to verify your status. It is essential that you obtain confirmation directly from the College before you begin practising. Do not rely on third-party information.

RCPSC Trainees

If you intend to begin practice on July 1, you must first ensure that your certificate has been issued. The majority of RCPSC trainee applications will be approved on June 29. Wait to receive our confirmatory email within 24 hours. You can also check the College's website beginning June 29. Enter your registration number in the "Find a Doctor" section. You may start independent practice only if "Independent Practice" appears in the Registration Class field. You may also call the Applications and Credentials Department at (416) 967-2617 between the hours of 10:00 a.m. to 5:00 p.m. on June 29. It is essential that you obtain confirmation directly from the College before you begin practising. Do not rely on third-party information.

Are you scheduled to continue in training on July 1?

If you are continuing in subspecialty training or clinical fellowship and are intending to hold an Independent Practice certificate when you begin that training on July 1, all of the rules and time frames noted above apply to you.

If you decide to renew your Postgraduate Education certificate for July 1 instead of applying for an Independent Practice certificate, your Postgraduate Education payment cannot be refunded nor can it be credited towards any future application for an Independent Practice certificate.

What are my options if I am not successful in passing the CFPC, RCPSC or MCCQE2 examination?

Applicants who do not pass the RCPSC or CFPC examination and wish to continue with their applications may apply under the College's "Restricted Certificates of Registration for Exam-Eligible Candidates" policy. See page 6 for further information.

Applicants who do not pass the RCPSC or CFPC examination may also place their Independent Practice application on hold for one year from the date of receipt.

Any such applicants needing to continue in subspecialty training or clinical fellowship immediately after completing residency, must ensure to renew the Postgraduate Education certificate of registration as soon as examination results are announced. Information on renewal is available on our website. Should you have any questions, please contact PGE Renewals at 1 800 268-7096, Extension 673.

Parts 1 and 2 of the Medical Council of Canada Qualifying Examination (MCCQE)

Successful completion of MCCQE Parts 1 and 2 is required for issuance of an Independent Practice certificate of registration. If not available in your physiciansapply.ca profile, provide a photocopy of your pass results on the MCC examinations.

If you are scheduled to take the upcoming MCCQE Part 2, notice of your pass results will be forwarded on your behalf to the College by the Medical Council of Canada.

Notice will be sent as quickly as permitted by the MCC. Although the notification procedure is efficient and reliable, should the notice be delayed for any reason, it would be your responsibility to follow up with the MCC.

Evidence of Standing

If you engaged in any practice outside of Ontario that was not an approved part of your Ontario residency program requirements or undertook an out-of-Ontario residency elective of six months or longer, you must provide evidence of good standing from the medical licensing authority concerned.

The College's Confirmation of Standing form, available on our website, should be used for this purpose.

A certificate of standing is acceptable in lieu of the "Confirmation of Standing" form only if the licensing authority will not complete the Consent form and only if the certificate of standing attests to the same information as required on the Confirmation form.

Restricted Certificates of Registration for Exam Eligible Candidates Policy

Applicants who do not pass the RCPSC/CFPC or MCCQE exams and wish to continue with their applications may apply under the College's "Restricted Certificates of Registration for Exam Eligible Candidates" policy.

Such applications require approval by the Registration Committee. The Registration Committee meets once every four to six weeks. Please refer to the Registration Policies page of the College's website to review this policy and Guidelines for College-Directed Supervision along with information about Registration Committee process, deadlines and meeting dates.

No advance assurances can be given regarding the outcome of Registration Committee review.

If you wish to have your application considered under this policy, you must contact inquiries@cpso.on.ca for a list of the additional credentialing requirements.

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 certificate. If a physician intends to change scope of practice, s/he 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.

Annual Renewal of the Certificate

Upon issuance of a 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 online completion of the mandatory renewal form. The College does not offer reduced membership fee for members on leave, residing out-of-province, or otherwise not using their certificate.

For members holding an Independent Practice 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.

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

Credit Card Payment Authorization for Independent Practice Certificate Fees



THE COLLEGE
OF
PHYSICIANS
AND
SURGEONS
OF
ONTARIO

80 College Street,
Toronto, Ontario,
Canada
MSG 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#):

Applicant Given Name(s):

Applicant Surname:

Street Address: City:

Province/State: Postal Code/Zip: Country:




Email Address: Phone Number:

- \$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.

- \$487.50 - Expedited Assessment Fee - Independent Practice
- \$162.50 - 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 _____

If you do not have a CPSO number, leave this field blank. The College will notify you of your assigned file number shortly after the receipt of your application.

physiciansapply.ca Candidate Code _____

If you have a physiciansapply.ca account, before submitting this application, ensure to authorize sharing of all medical degree credentials submitted to physiciansapply.ca for source verification. If applicable, also share the Medical Council of Canada examination results through your profile on physiciansapply.ca.



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.

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 Year

Expiry Date: _____ / _____
Month Year

Sub-specialty, if applicable: _____

Yes No

Certification Date: _____ / _____
Month Year

Expiry 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 |
|------------|----------------|---------------|-----------------|---------------|
| | | | / | / |
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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 |
|-------|------------|----------------|---------------|--------------------|------------------|
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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 |
|------------|----------------|---------------|--------------------|------------------|
| | | | / | / |
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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

8. PRACTICE HISTORY

In chronological order, list the names of every jurisdiction where you have practiced medicine, including all postgraduate training appointments since graduating from medical school. If you held or currently hold a licence issued by a medical licensing authority, regardless of type, please provide the corresponding licence or registration number for each period of postgraduate training and/or practice. Reflect actual postgraduate training and clinical practice history, rather than dates of licensure. Jurisdictions where you held a licence, but did not engage in medical practice or training, are not required in this section.

| Jurisdiction (Province, State or Country) | Nature/Type of Postgraduate Training and Medical Practice | From Month/Year | To Month/Year | Licence Number |
|--|--|--------------------|------------------|-------------------|
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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@cpso.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"/> |
|--|--|

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 current report on your medical condition setting out your diagnosis, course of treatment, present 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, hepatitis, etc.)? | 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 delayed commencement of postgraduate training after graduation from medical school <u>and/or</u> have you ever interrupted or ceased postgraduate training and/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 medical identification number system has been developed with the goal of providing a reliable means of identifying every individual in the Canadian medical education and practice systems.

A not-for-profit corporation (whose legal name is noted above), 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.

A MINC number will be issued to all individuals (who consent in writing) at the time of their initial, even temporary, entry to any aspect of the Canadian medical education or practice systems, including undergraduate students, postgraduate trainees, applicants to the MCC examinations, and physicians of any registration status. Once assigned, an individual's MINC number will remain unchanged throughout his/her entire medical career. Assigned numbers will never be reused, even after the death of the individual. Individuals will carry the same MINC number, even if they leave Canada and return, move between jurisdictions or change registration status.

No information is encoded in an individual's MINC number, other than 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.

Upon the consent of an individual, the MCC or a provincial/territorial medical regulatory authority will submit personal information to MINC#NIMC as follows: name(s), gender, date of birth, country of birth and year and university of graduation (note: previous names if applicable and other identifiers if necessary to confirm identity may also be submitted), collectively referred to as the Core Information.

MINC#NIMC will use Core Information to either generate or confirm a MINC number for individuals and will retain the Core Information and its associated MINC number in its system for

the purposes of uniquely identifying individuals and ongoing identity confirmation by Prime Users and Licensed Users of the MINC system. Prime Users are the 12 medical regulatory authorities in Canada, as well as the MCC.

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 number system as a means of accurately identifying individuals with whom they have dealings, processing information relating to those individuals, and 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.

Licensees 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 MCC and the twelve Canadian medical regulatory authorities will have controlled access to both MINC numbers and Core Information in order to facilitate the performance of their regulatory responsibilities. The only information that shall be disclosed to Licensed Users shall be the MINC numbers for their own members.

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

MINC#NIMC Corporation
1021 Thomas Spratt Place Ottawa, ON, K1G 5L5
Attention: Mr. John E. Swiniarski, Executive Director
Telephone: (613) 288-2792 / 1-855-288-2783
Email: info@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 release by the College of Physicians and Surgeons of Ontario of my 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 and my Core information in its database and disclosing the MINC number to Prime and Licensed Users and my Core Information to Prime 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

Updated by MINC#NIMC Nov/2017

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