Application for Independent Practice Certificate of Registration:
Holders of Full Unrestricted Licence from Out-of-Province

Use this application only if you currently hold a full unrestricted undefined licence to practise in another Canadian province or territory (except Nunavut*) that is equivalent to an Independent Practice certificate of registration in Ontario.

Your application will be reviewed and processed under the provisions in the Ontario Regulated Health Professions Act relating to the Agreement on Internal Trade (AIT).

Important! Do not use this application if you hold a full or other type of licence in Canada that is in any way defined or limited by scope, location, term, specialty, field of practice, etc.

Use instead the “Application for Registration: Holders of Defined, Provisional, Special (or similar) Licence from Out-of-Province”.

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

The package contains the following:

Instruction Guide:
- Key Points Regarding Application Process and Timelines
- Schedule of Requirements
- Requirements Checklist

Forms:
- Application Form
- Credentialing Forms
- Payment Form

Should you have any questions, please contact the Inquiries Section in the Registration Department at (416) 967-2617.

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

* “Out-of-Province licence” means a licence or certificate to practise medicine granted by a medical regulatory authority in a Canadian province or territory that is a party to the Agreement on Internal Trade. Nunavut is not yet a party to the AIT.*
Please note the following rules and time frames of the College’s registration process. They apply to all applicants and must be followed carefully to enable efficient and timely processing of your application.

### Submitting your Application

- Submit your application form and fee and begin arranging for all supporting documents at least two to three months in advance of your intended starting date. This will provide sufficient lead time for most applicants.
- You are responsible for your application and for completing all requirements exactly as instructed.
- Mail or courier your application and payment to the College. An official receipt for payment will be mailed to you shortly afterwards. This will be our acknowledgement that we have received your application.
- Faxed application forms are not acceptable and no action will be taken on them.

### Out-of-Province Licence Equivalent to CPSO Independent Practice Certificate

- Your eligibility under the AIT provisions is based on your full, unrestricted and undefined licence in another Canadian province or territory that is equivalent to an Independent Practice certificate in Ontario.
- Ensure that your out-of-province licence remains active throughout the application process. If it expires, is suspended, or becomes inactive, your application cannot be processed under the AIT provisions.

### Initial Assessment of your Application

- Applications are assessed in the order they are received. March to July is our peak period.
- Wait time between receipt of application and initial assessment is usually two to four weeks, but can be longer during our peak period. Until this initial assessment is completed, the College is unable to respond to inquiries on application status or receipt of supporting documents.
- After assessment, the College will notify you by email regarding any missing documents. Be sure to advise the College if you change your email address or contact information.

### Supporting Documents

- Do not delay in arranging for all required supporting documents as listed in the schedule. Note that any affirmative responses to section 9 in the application form will also require supporting documents.
- Some required documents, e.g. evidence of standing, will become outdated and unacceptable if submitted too far in advance. Six months is the maximum term of validity for such documents.
- Evidence of good standing is required from every jurisdiction where you have practised or trained.
- Documents received at the College, whether by mail or fax, take a minimum of two business days to be logged and filed. We are unable to confirm receipt of a document or fax until then.
- Ensure that all required primary-source verifications of your credentials are sent directly to the College from the source. Verifications sent by you or via a third party will be rejected.

### Registration Committee Review (if necessary)

- 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.

### Issuance of Your Certificate

- If you have completed all requirements but have not received your certificate, please contact the College to confirm that you are registered. Practising without a valid certificate of registration is an offence in Ontario.
Non-Exemptible Requirement for Registration

In addition to the requirements listed in the schedule, every applicant for registration must satisfy the following **non-exemptible** requirement:

*The applicant's conduct, 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.*

If any issues are presented that call into question an applicant's compliance with this requirement, the application must be reviewed by the Registration Committee.

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

Upon completion of all application requirements and processing by the Registration Department, the College will issue an Independent Practice certificate of registration.

Every Independent Practice certificate carries the following standard term, condition and limitation:

*The certificate holder may practise only in those areas of medicine in which the holder is 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.

Specialist Recognition

The College’s rules on recognition of specialists are set out in its policy, “Recognition of Non-Family Medicine Specialists.” All registration applicants should read this policy, which is posted on the College’s website under Registration Policies. Only those physicians who meet the criteria in this policy can be recognized by the College as specialists.

Fee for Service Billing Number

Eligibility for a fee-for-service billing number in Ontario is contingent on issuance of the Independent Practice certificate. 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 his or her membership each year through full payment of annual membership fee and completion of the mandatory membership 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.
SCHEDULE OF REQUIREMENTS

These requirements for an Independent Practice certificate apply to applicants already holding a full unrestricted licence in another Canadian province or territory that is equivalent to an Independent Practice certificate.

- **PART A** - Requirements to be returned by you with your application form.
- **PART B** - Requirements you must arrange to be completed by the source organization.

All requirements must be completed. Please ensure that you follow instructions carefully.

**PART A: Requirements to be submitted with your Application**

1) **Application Form**

   Your application form must be fully completed and the declaration on the last page must be signed and sealed by a commissioner for oaths, notary public, or lawyer. If the lawyer does not use a seal, a business card must be attached. An incomplete form or a form not properly notarized will be returned.

   Ensure that your photograph is full face, of passport size and quality, and taken within sixty days of completing the form. A photograph not meeting these specifications will be returned.

   **In part 9, 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. Processing of these applications usually takes longer, and therefore we encourage such applicants to apply early.**

   Applications not completed after one year will be considered withdrawn.

2) **Full UnrestrictedUndefined Licence in a Canadian Province or Territory**

   Photocopy of your full, unrestricted and undefined licence or certificate of registration issued by a medical regulatory authority in a Canadian province or territory that is equivalent to an Independent Practice certificate in Ontario.

   Your licence must be current, must authorize you to practise medicine independently in that jurisdiction, and must not be defined or limited by scope, location, term, specialty, field of practice, etc. Depending on our review of your application, you may be asked to arrange for your licensing authority to write to the College with further details regarding your licence.

   If you hold more than one full unrestricted licence or certificate in Canada, provide a copy of each one.

3) **Declaration for Breaks in Training or Practice History**

   Using the Declaration form provided by the College, you must declare every break of three months or more in your postgraduate medical training or practice history. Breaks exceeding six months require a notarized declaration. Refer to the form for further instructions. A new form must be submitted with each application made to the College.

   If you have not practised for the past three years or practised less than six months over the past five years, your application will require review by the Registration Committee under the College’s Re-entry to Practice policy. For further details relating to this policy, visit the College’s website at [www.cps.on.ca](http://www.cps.on.ca), follow the Policies and Publications link from the home page.
4) **Report from the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)**

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

You must submit to NPDB-HIPDB a Self-Query request for information disclosure, and then forward to the College the reports you receive from NPDB-HIPDB.

If you receive a rejection notice from NPDB-HIPDB, do not forward it to the College. Instead, re-submit your Self-Query to NPDB-HIPDB.

Note that the Self-Query must be submitted through the NPDB-HIPDB website. For further instructions and to start the Self-Query process, go to [www.npdb-hipdb.com](http://www.npdb-hipdb.com).

Note: NPDB-HIPDB reports are not required if you have not practised medicine or taken postgraduate medical training in the United States.

5) **Professional Liability Protection in Ontario – Declaration or Undertaking**

All applicants must have adequate professional liability protection, either from the Canadian Medical Protective Association (CMPA) or an Ontario insurance company, or under the Treasury Board Policy for Indemnification of Crown Servants of Canada.

(i) Complete the “Declaration” form if you now have professional liability protection in Ontario. Using the Declaration form provided by the College, you must declare that you have professional liability protection that complies with the College’s by-law. See the Declaration for further instructions.

(ii) Complete the “Undertaking” form if you do not yet have professional liability protection in Ontario. If you do not yet have professional liability protection in Ontario, complete the College form “Undertaking: Professional Liability Protection.”

Note: Although you can be registered by the College based on your Undertaking, you must not commence any medical practice until you obtain professional liability protection. After you obtain it, you must submit a Declaration to the College within 30 days.

6) **Consent to Disclosure of Criminal Record Information**

A criminal record check using the Canadian Police Information Centre (CPIC) database is required. To complete this requirement, choose one of the following two options:

**Option A:** For the College to obtain a CPIC check on your behalf, submit the following:
- Completed consent form
- Photocopy of two pieces government-issued photo ID (e.g. driver’s licence and birth certificate)
- Payment of processing fee of $15. Payment must be made by Visa, American Express, MasterCard (using the College form) or by money order or certified cheque payable to CPSO. Note that personal cheques are not accepted.

The College will obtain a CPIC check on your behalf from the Ontario Provincial Police - minimum 15 business days processing time. For further instructions see the Consent form.

**Option B:** Make your own arrangements to obtain a valid CPIC check from a municipal or provincial police service in Canada. See enclosure for further instructions.

Option B is strongly recommended if you apply late and have an urgent starting date.

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.
7) **Canadian Citizenship or Permanent Resident Status**
   
   One of the following is required:
   
   (i) Proof of Canadian citizenship (photocopy of your Canadian birth certificate, Canadian baptismal certificate, Canadian passport or Canadian citizenship card). Date of birth must be shown.
   
   (ii) Proof of 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).
   
8) **Evidence of Name Change (if applicable)**
   
   Evidence of all official name changes must be submitted with your application (i.e. marriage certificate, official court order). In entering your name on the register, the College will use the name provided on your medical school documentation and supported by other identification documents unless you have officially changed your name.
   
9) **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, duration 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.
   
10) **Copies of LMCC, CCFP, FRCSC/FRCPC Certificates (if applicable)**
   
   If you have any of the following Canadian qualifications, provide photocopies of your certificates:
   
   - Licentiate Certificate of the Medical Council of Canada (LMCC)
   - Certification by the College of Family Physicians of Canada (CCFP)
   - Certification by the Royal College of Physicians and Surgeons of Canada (FRCSC/FRCPC)
   
   Your eligibility under the AIT provisions is not based on these qualifications, but your submission of them will ensure they are entered in the College’s register.
   
11) **MINC Consent Form**
   
   The MINC number is a national identifier unique to each physician in Canada, but contains no encoded personal information. It is used by approved Canadian medical regulatory, administrative and research bodies. See enclosure for further information.
   
   Your completed MINC Consent form will enable the CPSO to arrange for issuance of your MINC number. If you already have a MINC number or are not sure whether you have one, please provide your MINC Consent. Only with your Consent can we check for your existing MINC number.
12) **Payment of Fees ($2126.00)**

- **Application Fee (non-refundable):** $716.00
- **Membership Fee:** $1410.00

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.

**Total fees payable are $2141.00 if using Option A for CPIC check.**

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. Changes to fees apply to applications in process.

See page 9 for a breakdown of the Application fee.

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**PART B: Requirements to be sent by Source Organization**

- You must arrange for the documents below to be sent directly to the College by the source organization.
- Source documents sent by you or via a third party will be rejected.
- They must arrive by mail in an official, sealed and stamped envelope from the source organization.
- 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.
- Source documents not written in English or French must be supplemented by English or French translations obtained by the applicant. See the Notes section of this schedule for further details.
- Documents not meeting these requirements will not be accepted.

13) **Medical School Transcript** ***Graduates from an Ontario medical school may skip this requirement.***

Arrange for an official sealed transcript verifying your undergraduate medical education and conferral of degree in medicine to be sent directly to the College from your medical school. If you attended more than one medical school, an official transcript is required from each school.

**Alternative to Medical School Transcript Requirement:**

(i) If your medical school does not issue official transcripts, you must instead arrange for the school to complete a Certification of Medical School Graduation form. Blank forms are available from the College.

(ii) If you are an International Medical School Graduate who has previously had your medical degree credentials source-verified by the Physician Credentials Registry of Canada, you may request the PCRC to enable you to share your verified documents with the College. Complete the Consent for PCRC Document Sharing form (available from the College), mail or fax your completed Consent form to PCRC and provide the College with a copy of your completed form.
14) **Evidence of Standing - all Current and Past Jurisdictions**

Using the “Confirmation of Standing” form provided by the College, you are required to arrange for evidence of standing from the medical licensing authority in every jurisdiction where you have practised medicine or taken postgraduate training.

The evidence of standing from your current jurisdiction(s) must also confirm that you presently hold a full unrestricted undefined licence.

A certificate of standing issued in a form other than the College’s “Confirmation of Standing” form is acceptable if it attests to the same information as requested in the College’s form.

Note that evidence of standing from your current jurisdiction(s) is valid only for six months from date of issuance. Updated evidence will be required if your application remains in process after six months.

2) **Reference Forms**

Using the Reference Form provided by the College, arrange for three references to be completed by the following individuals at the hospital where you presently practise: chief of staff; department head; chief nurse. Instruct your referees to send their completed reference forms directly to the College.

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

Return with your application your “List of Referees” using the enclosed form. If you are unable to arrange for reference forms from the individuals specified above, please provide an explanatory letter.

3) **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 form 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 fax the Inquiry form to the Federation at (817) 868-4099.

Note: A Board action search and completion of the Inquiry form is not required if you have not practised medicine or taken postgraduate medical training in the United States.
IMPORTANT NOTES

Translations

All documents and letters not written in the English or French language must be accompanied by certified English or French translations. **All translations must be certified by one of the following:**

(i) A Certified Member of the Association of Translators and Interpreters of Ontario (ATIO). To find a certified translator, please visit their website: [www.atio.on.ca](http://www.atio.on.ca). Translations completed by a certified member of the equivalent Association of Translators and Interpreters in another Canadian province/territory are also acceptable.

(ii) A Canadian Embassy overseas or a foreign embassy or consular office in Canada authorized to certify translations.

Translations sent by the medical school are acceptable provided they are dated and stamped by the medical school to verify the contents and are received directly from the medical school with the original language document. Translations not meeting the above requirements are not acceptable.

Requirements Subject to Change

The registration requirements are subject to change without notice. Applicants must meet all current requirements. Enquiries concerning changes to the regulation should be directed to the Registration Department of this College. It is an offence under the Regulated Health Professions Act for a person to practise medicine in Ontario until such time as an appropriate certificate of registration has been issued.


Under 51(6) of the College by-law, the requirement for professional liability protection does not apply to members who,

(i) provide acceptable written evidence they are not providing any medical services to any person in Ontario, or

(ii) provide acceptable written evidence from their employer that they are only providing medical services to other employees and any liability claim against the members will be covered by their employer.

Applicants who qualify under either of these exemption provisions must telephone the Registration Department to discuss their case.

Explanation of Application Fee

The Application fee consists of the Application fee of $705 and a Fairness Commissioner Registration Audit Recovery fee of $11.

Confidentiality

The College preserves secrecy with respect to all information it receives in connection with applications for registration, except in accordance with the following provisions in s. 36 of the Regulated Health Professions Act (Ontario):

(a) to the extent that the information is available to the public under this Act, a health profession Act or the Drug and Pharmacies Regulation Act;

(b) in connection with the administration of this Act, a health profession Act or the Drug and Pharmacies Regulation Act, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members’ incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) to a body that governs a profession inside or outside of Ontario;

(d) as may be required for the administration of the Drug Interchangeability and Dispensing Fee Act, the Healing Arts Radiation Protection Act, the Health Insurance Act, the Independent Health Facilities Act, the Laboratory and Specimen Collection Centre Licensing Act, the Ontario Drug Benefit Act, the Coroners Act, the Controlled Drugs and Substances Act (Canada) and the Food and Drugs Act (Canada);

(e) to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(f) to the counsel of the person who is required to keep the information confidential under this section;

(g) to confirm whether the College is investigating a member, if there is a compelling public interest in the disclosure of that information;

(h) where disclosure of the information is required by an Act of the Legislature or an Act of Parliament;

(i) if there are reasonable grounds to believe that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons; or

(j) with the written consent of the person to whom the information relates. 2007, c. 10, Sched. M, s. 7 (1).
REQUIREMENTS CHECKLIST

This checklist summarizes the schedule of requirements and is provided as an aid to organizing your application. Ensure that you follow the instructions in the schedule when completing each requirement.

<table>
<thead>
<tr>
<th>Part A: Requirements to be submitted with your Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Application Form</td>
</tr>
<tr>
<td>Ensure all questions are answered and the declaration on the last page is properly completed.</td>
</tr>
<tr>
<td>2. Full Unrestricted Undefined Licence in a Canadian Province or Territory</td>
</tr>
<tr>
<td>Photocopy of your current full unrestricted licence issued by a medical licensing authority in Canada.</td>
</tr>
<tr>
<td>3. Declaration for Breaks in Training or Practice History</td>
</tr>
<tr>
<td>Explain any breaks of three or more months in your training or practice history using the form.</td>
</tr>
<tr>
<td>4. Report from NPDB and HIPDB Data Banks</td>
</tr>
<tr>
<td>If you have practised or trained in the USA, obtain NPDB &amp; HIPDB report.</td>
</tr>
<tr>
<td>5. Professional Liability Protection</td>
</tr>
<tr>
<td>Complete the Declaration or Undertaking form.</td>
</tr>
<tr>
<td>6. Consent to Disclosure of Criminal Record Information</td>
</tr>
<tr>
<td>Option A: Complete consent form and return with copy of two pieces government-issued photo ID and fee.</td>
</tr>
<tr>
<td>Option B: Arrange your own CPIC check.</td>
</tr>
<tr>
<td>7. Canadian Citizenship or Permanent Resident</td>
</tr>
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<td>Copy of Canadian birth certificate, Canadian passport or permanent resident card with date of birth shown.</td>
</tr>
<tr>
<td>8. Evidence of Name Change (if applicable)</td>
</tr>
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<td>9. Curriculum Vitae</td>
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<td>Curriculum vitae must list all qualifications; dates/locations of all training and practice appointments.</td>
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<td>10. Copies of LMCC, CCFP, FRCPC/FRCSC (if applicable)</td>
</tr>
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<td>If you possess any of LMCC, CCFP or FRCSC/FRCPC, provide photocopies of your certificates.</td>
</tr>
<tr>
<td>11. MINC Consent Form</td>
</tr>
<tr>
<td>Sign and return MINC Consent form to enable issuance of (or verification of existing) MINC number.</td>
</tr>
<tr>
<td>12. Payment of Fees</td>
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<td>Application fee must be enclosed with your application. Personal cheques not accepted.</td>
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<tr>
<th>Part B: Requirements to be sent to College by Source Organization</th>
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<tbody>
<tr>
<td>13. Official Transcript from Medical School</td>
</tr>
<tr>
<td>Arrange for your official undergraduate transcripts to be sent directly to College by your medical school.</td>
</tr>
<tr>
<td>14. Evidence of Standing and Current Full Unrestricted Licence</td>
</tr>
<tr>
<td>Send CPSO form to licensing authority in every jurisdiction where you have practiced or trained.</td>
</tr>
<tr>
<td>15. Reference Forms</td>
</tr>
<tr>
<td>Send the College reference forms for completion to chief of staff, department head and chief nurse.</td>
</tr>
<tr>
<td>16. Inquiry Form for Board Action Search by the Federation of State Medical Boards (FSMB)</td>
</tr>
<tr>
<td>If you have practised or trained in the USA, send Inquiry form to FSMB.</td>
</tr>
</tbody>
</table>

Rev. June 2, 2010
DECLARATION:
To Account for Breaks in Training or Practice History

Instructions to Applicant:
- Use this form to declare and account for all periods, since your graduation from medical school, during which you did not practise medicine either as a postgraduate clinical trainee or as a clinical practitioner in any capacity.
- Declare only those periods of three continuous months or more.
- If any periods exceed six months, Declaration must be notarized by a lawyer, commissioner for oaths or notary public.
- Once completed, enclose with application form and return to the College’s Registration Department.
- Do not return form if you have no breaks to declare.

Applicant’s Declaration:

I declare that after I graduated from medical school, I ceased practising medicine for three continuous months or more on the following occasions:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Reason for Break</th>
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<tbody>
<tr>
<td>(mo./yr. to mo./yr.)</td>
<td>(explain why you took a break, e.g. maternity leave, vacation, immigration; attach additional pages as necessary)</td>
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</tbody>
</table>


I make this declaration conscientiously believing it to be true, and knowing that it is of the same legal force and effect as if made under oath.

_________________________            _________________________            ___________________
Applicant’s Signature                                                             Print Name                                                               Date

Note: If any breaks exceed six months, Declaration must be notarized below:

Declared before me in ________________________________ on __________.

City, Town, County Province, State Country Date

Signature of a Commissioner for Oaths, Lawyer or Notary Public

_________________________            _________________________            ___________________
Affix Seal or Business Card of Notary, etc.

Print Name and Address of Commissioner for Oaths, Lawyer or Notary Public
Declaration by Applicant:
Professional Liability Protection

Under the College’s registration regulation, applicants for registration must have professional liability protection in compliance with the College’s by-laws.

Applicants are required to sign a declaration that they comply with s. 50.2 of the by-law, 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).

Complete and return this Declaration to the College as evidence of your professional liability protection.

This form must be signed, dated and returned to the College no more than six months in advance of expected date of registration. An incomplete or outdated form will not be accepted.

Mail or fax completed form to:  
Registration Department  
College of Physicians and Surgeons of Ontario  
80 College Street, Toronto, ON, Canada M5G 2E2  
Fax: (416) 967-2623

**IMPORTANT!**  Do not complete this form if you do not yet have professional liability protection and are applying to the Canadian Medical Protective Association. Instead, complete the form “Undertaking by Applicant: Professional Liability Protection.”

See over for Declaration…
Declaration by Applicant: Professional Liability Protection

I, ________________________________________, hereby declare to the College of Physicians and Surgeons of Ontario (“the College”) as follows:

1. I currently have professional liability protection that extends to all areas of my practice in Ontario.

2. My professional liability protection is provided through:

   □ a) membership in the Canadian Medical Protective Association (“CMPA”), under membership no.: ________________________, or

   □ 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

   □ c) coverage under the Treasury Board Policy on Legal Assistance and Indemnification (for Crown servants of Canada).

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 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.

4. I understand that I must have available in my office, in written or electronic form, for inspection by the College, evidence that I have professional liability protection.

5. I understand that my registration with the College will expire when I no longer have professional liability protection.

6. I understand that before each annual renewal of my College registration, I must sign a declaration that I have professional liability protection.

7. 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.

8. 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.

____________________________________________  ______________________________
Signature of applicant                                      Date

_______________________________________________________   _____________________________________
Print name of applicant                                      College reference number (if known)

Mail or fax this completed form to: Registration Department
College of Physicians and Surgeons of Ontario
80 College Street, Toronto, ON, Canada M5G 2E2
Fax: (416) 967-2623

Note: Incomplete forms cannot be accepted and will be returned.
**Undertaking by Applicant:**

**Professional Liability Protection**

Under the College’s registration regulation, applicants for registration must have 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,
  - membership in the Canadian Medical Protective Association;
  - 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;
  - coverage under the Treasury Board Policy on Legal Assistance and Indemnification (for Crown servants of Canada).

This Undertaking must be completed if you do not yet have professional liability protection in Ontario and need to be registered with the College in order to qualify for professional liability protection. For example, if you are applying to the Canadian Medical Protective Association for the first time, you will need to complete this Undertaking.

This form must be signed, dated and returned to the College no more than six months in advance of expected date of registration. An incomplete or outdated form will not be accepted.

Mail or fax completed form to:  
**Registration Department**  
College of Physicians and Surgeons of Ontario  
80 College Street, Toronto, ON, Canada M5G 2E2  
Fax: (416) 967-2623

Note: You will need to submit a Declaration to the College within 30 days of obtaining your professional liability protection. A form for this purpose will be enclosed with your certificate of registration.

See over for Undertaking…
Undertaking by Applicant:
Professional Liability Protection

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 have professional liability protection.

5. I understand that my registration with the College will expire when I no longer have professional liability protection.

6. I understand that before each annual renewal of my College registration, I must sign a declaration that I have 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.

____________________________________________  ______________________________
Signature of applicant  Date

_______________________________________________________   _____________________________________
Print name of applicant  College reference number (if known)

Mail or fax this completed form to: Registration Department
College of Physicians and Surgeons of Ontario
80 College Street, Toronto, ON, Canada M5G 2E2
Fax: (416) 967-2623

Note: Incomplete forms cannot be accepted and will be returned.
Consent to Disclosure of Criminal Record Information: Options

A criminal record check using the Canadian Police Information Centre (CPIC) database is required. To complete this requirement, choose one of the following two options:

**Option A**: Submit the enclosed consent form. The College will obtain a CPIC check on your behalf from the Ontario Provincial Police (OPP) - Minimum 15 business days processing time.

**Option B**: Make your own arrangements to obtain a valid CPIC check from a municipal or provincial police service in Canada.

**Option B is strongly recommended if you apply late and have an urgent starting date.**

If the 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. Positive results may require further review and documentation.

Criminal record check results are kept confidential.

**Option A - Complete and submit the Consent form**

**Include a photocopy of two pieces of government photo identification.** Health cards and social insurance cards are not acceptable.

Make certain your name and date of birth information is accurate and matches the information in your application form. **Any omissions or discrepancies will require returning the form to you for correction.** All name variations must be included on your form (maiden name, official name changes, or alternate spellings). Enter “physician” in Professional Position field.

Once signed and dated, the consent is valid for 1 month only. Return the form immediately after you complete it.

The OPP requires a minimum of 15 business days to complete the check. The College can neither expedite this check nor process your application without it. Results are valid for six months.

**Option B - Do not complete the Consent form**

Obtain and submit to the College a valid clearance letter or certificate from a municipal or provincial police service in Canada (must be listed in the CPIC National Directory at www.cpic-cipc.ca).

Original is required. Must be on police service letterhead and contain original signature(s) and date of issuance. A "vulnerable sector" check is not required.

Your name and date of birth in the CPIC results must match your College application.

CPIC results are valid for six months from date of issue and must be updated if necessary.

You are responsible for any fee charged by the police service. The College cannot reimburse this fee.

Some municipal police services will conduct checks only for local residents. If necessary, refer to the CPIC National Directory to locate a Canadian police service that will conduct your check.

**Online Checks by Commercial Vendors:** Acceptable only if the document containing the results shows results of a CPIC check conducted by a Canadian police service and signed by authorized police personnel. Other Option B criteria also applies.

See over for Consent form…

June 2, 2010
CRIMINAL RECORD INFORMATION
AUTHORIZATION FORM

The purpose of the criminal record check is to further the objects of the College of Physicians and Surgeons of Ontario as set out in section 3(1) of the Health Professions Procedural Code.

<table>
<thead>
<tr>
<th>Surname</th>
<th>Given Name</th>
<th>Middle Name(s)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>yyyy</td>
</tr>
</tbody>
</table>

Maiden Name or Other Names used (if applicable)(all legal names in lifetime)

Current Mailing Address (number, street, apt, lot, concession, township, rural route #, city, postal code)

S.I.N. not necessary

Professional Position and Location

CONSENT
I hereby consent to the disclosure of my clean record or my criminal convictions for which a pardon has not been granted, records of discharges which have not been removed from the CPIC system in accordance with the Criminal Records Act, and records of outstanding criminal charges of which the OPP is aware to the following persons:
The College of Physicians and Surgeons of Ontario.

FINGERPRINT VERIFICATION
If I deny that I am the offender with the criminal record so provided, I may present myself to the police in my jurisdiction to determine whether my fingerprints match those associated with the criminal record. No other defence is afforded me, but, if I am a physician, I will have a hearing at the College before my certificate of practice is denied, restricted or removed.

RELEASE
I hereby release and forever discharge Her Majesty the Queen in right of Ontario, the OPP, the Commissioner of the Ontario Provincial Police and the College of Physicians and Surgeons and any or all of their respective members, directors, employees, servants, and agents, from any and all actions, claims and demands for damages, loss or injury howsoever arising which may hereafter be brought against them, jointly or severally, as a result of their participation in this criminal records check on me.

Signature  Date

MY INFORMATION CONTACT FOR QUESTIONS ABOUT MY CRIMINAL RECORD CHECK:
Rocco Gerace, Registrar
The College of Physicians and Surgeons
Phone: 416-967-2617

June 2, 2010
Consent for Release of Information to
Medical Identification Number for Canada (MINC)

To receive your Medical Identification Number for Canada (MINC), you need to complete this consent. Please read the details about the MINC system and answer the question below.

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

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.

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.

Yes ☐ No ☐

Print Full Name __________________________________ Signature __________________________ Date _______________________

CPSO Registration or Reference Number (if known): ____________________________ April 9, 2010
READ INSTRUCTIONS CAREFULLY:

DO NOT SEND INCOMPLETE FORM BACK TO THIS COLLEGE.

IT IS YOUR RESPONSIBILITY TO HAVE THIS FORM COMPLETED BY ALL MEDICAL LICENISING AUTHORITIES WHERE YOU HAVE BEEN REGISTERED.

INFORMATION PROVIDED ON THIS FORM IS VALID FOR SIX MONTHS ONLY. UPDATED INFORMATION WILL BE REQUIRED IF YOUR CERTIFICATE OF REGISTRATION IS NOT ISSUED WITHIN THAT PERIOD.

CONFIRMATION OF STANDING
by Medical Licensing Authority

Consent to Release Information
to the College of Physicians and Surgeons of Ontario

- This section to be completed by the Applicant -

To the Medical Licensing Authority in: __________________________________________________________
(province, state, territory or 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 your releasing to the College of Physicians and Surgeons of Ontario all information requested below and any other information respecting me 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 appended information to be forwarded directly to:

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

I understand you may require a fee for this service.

______________________________
Full Name of Applicant (Print or Type)

______________________________
Signature of Applicant

______________________________
Date

______________________________
Licence Number

*Note to Applicant: A completed form is required from the medical licensing authority in every jurisdiction where you have practised medicine, postgraduate training appointments included. Photocopy this form if you need additional copies.
- This section to be completed by the Medical Licensing Authority -

1. This is to verify that,

   Dr. ________________________________  
   **Full Name of Applicant**

   a) Graduated From: ________________________________  
      **Name of Medical School**

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

      | Type of Licence | Licence Number | Date Issued | Date Expired or Cancelled |
      |------------------|----------------|-------------|-----------------------------|
      |                  |                | month / year| month / year                |
      |                  |                |             |                             |
      |                  |                |             |                             |
      |                  |                |             |                             |
      |                  |                |             |                             |

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

      | Specialty | Granted By | Date |
      |-----------|------------|------|
      |           |            | month / year |
      |           |            |             |
      |           |            |             |
      |           |            |             |

   d) Undertook the following postgraduate training appointment(s) in the jurisdiction governed by this medical licensing authority:

      | Type of Program | Hospital/University | From/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 [ ]

If “yes” has been answered to question 2, 3, 4 or 5 please provide all relevant information and documentation.

Name and Title of Official for Medical Licensing Authority ____________________________

Name of Medical Licensing Authority ____________________________

Signature of Medical Licensing Authority Official ____________________________

Date ____________________________

Mailing Address ____________________________

Email Address ____________________________

Telephone Number ____________________________

Fax Number ____________________________

Seal or Stamp of Medical Licensing Authority to be Affixed Here

*Note to the Licensing Authority: You may fax the completed form to the Registration Department, College of Physicians and Surgeons of Ontario. Please ensure the original is mailed promptly.

Rev. July 2008
REFERENCE FORM

Name of Applicant: _______________________________________________________________

Referee: Name and Position ___________________________________________________________

Hospital Name/Location ____________________________________________________________

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

Referee Information:

i. Is the applicant related to you? □ Yes □ No

ii. Are you in a position of formal authority over the applicant’s work? □ Yes □ No

iii. In what capacity have you worked with the applicant? (i.e. Chief of Staff, Program Director, Colleague, Nurse, etc.) __________________________________________________________

iv. How long have you worked with the applicant? _________________________________

v. Where have you worked with the applicant? _________________________________

Candidate Information:

I. Clinical Practice

Description of the candidate’s medical activities:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Superior | Fully Satisfactory | Satisfactory | Not Satisfactory | Unknown
---|---|---|---|---
Clinical knowledge
Clinical competence
Professional judgment
Technical skills
Problem solving ability
Discharge planning
Overall performance

Comments: __________________________________________________________________________

__________________________________________________________________________________

Page 1 of 3
II. Resource Utilization, and Administrative Duties

<table>
<thead>
<tr>
<th>Utilization of diagnostic and therapeutic agents</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness of medical record completion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of medical record documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares written documentation (e.g. patient notes, discharge summaries and patient letters) that are accurate, organized and timely</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-Call dependability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participates in administration and leadership roles, as appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at meetings/Committee participation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:____________________________________________________________________________
_____________________________________________________________________________________

III. Professional Attitude / Interpersonal Skills

<table>
<thead>
<tr>
<th>Oral communication skills</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate effectively and appropriately in an interprofessional health care team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes a therapeutic relationship and communicates well with patients and families</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship with other physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship with nursing staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates integrity, honesty, compassion and respect for others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional behavior (attitude/emotional stability)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:____________________________________________________________________________
_____________________________________________________________________________________

IV. Continuing Professional Development

<table>
<thead>
<tr>
<th>Participation in educational activities</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates lifelong learning skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aware of own limitations; seeks assistance and/or feedback; and accepts advice graciously</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:____________________________________________________________________________
_____________________________________________________________________________________
V. Strengths/Areas of Improvement

What are the applicant’s greatest strengths?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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

VI. Have you any additional information with respect to this applicant which may affect his/her application for registration to practice medicine in Ontario?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

VII. Summary Recommendation
(Please choose the most appropriate statement)

Recommend without reservation

Recommend with reservations (please explain below)

Do not recommend (please explain below)

Please call me to discuss this applicant

Phone number and the best time to contact you:
______________________________________________________________________________

Comments/Reservations:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Print Name: ______________________________ Title: _______________________________
Signature: _____________________________ Date: ________________

Thank you. We appreciate the time you took to complete this document.

Rev. June 7, 2010
LIST OF REFEREES

This form is to be completed by applicants who are required to arrange for references. Please list below the names of the three referees to whom you have sent the College’s Reference Form for completion.

Three references are required from the hospital where you now practice:

1. Chief of Staff
2. Department Head
3. Chief Nurse

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

If you are currently completing your residency training in Canada, in lieu of the reference forms please arrange for a copy of your final in-training evaluation report (FITER) to be sent directly from your Program Director to the College.

This list will assist the College in efficient credentialing of your application. Return this form with your application.

Applicant’s Full Name: _________________________________________ Date: _____________________

APPLICANT’S REFEREES:

(1) Referee:
Name __________________________________________________________
Position _________________________________________________________
Hospital Name __________________________________________________
Location (municipality, province/state) ______________________________

(2) Referee:
Name __________________________________________________________
Position _________________________________________________________
Hospital Name __________________________________________________
Location (municipality, province/state) ______________________________

(3) Referee:
Name __________________________________________________________
Position _________________________________________________________
Hospital Name __________________________________________________
Location (municipality, province/state) ______________________________
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
Registration Department
80 College Street
Toronto, Ontario
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)         U.S.A. Social Security No.
(if applicable)
**REGISTRATION FEES:**
**VISA, MASTERCARD OR AMERICAN EXPRESS PAYMENT AUTHORIZATION**

Instructions to Applicant:
- Please provide all information below
- Return payment authorization form to: CPSO, 80 College Street, Toronto, ON M5G 2E2
- Ensure you authorize the correct payments - refer to application material or contact the Registration Department if necessary (Telephone: (416) 967-2617; Fax: (416) 967-2623)
- Application fee is not refundable
- College’s receipt of Application fees does not confirm that you are registered or are eligible for registration
- Mail OR fax this form but **DO NOT** do both (to avoid possible overcharge)

**PLEASE PRINT CLEARLY**

<table>
<thead>
<tr>
<th>Date:</th>
<th>d</th>
<th>d</th>
<th>m</th>
<th>m</th>
<th>y</th>
<th>y</th>
<th>y</th>
</tr>
</thead>
</table>

Your College Registration or File No. (if known): __________________________

Name: _____________________________________________

Address: __________________________________________

Telephone: __________________________ E-mail address: ______________________

I authorize the College to charge my:  

- [ ] VISA  
- [ ] MasterCard  
- [ ] American Express

Account No: ___________________________ Account Expiry Date: _______ _______

Cardholder’s Name: ____________________________________________

Total Amount to Charge: $ _______ (Canadian Funds)

**For payment of (check below):**

- [ ] $152 Application Fee - Postgraduate Education class  
- [ ] $15 Criminal Record Check Processing Fee

- [ ] $282 Membership Fee - Postgraduate Education class

- [ ] $716 Application Fee - Independent Practice and all other classes

- [ ] $1410 Membership Fee - Independent Practice and all other classes

- [ ] $293 Application Fee - Short Duration class

- [ ] $ _______ Other: ___________________________

Signature of cardholder required: ____________________________________________

Fees are subject to change. Charges returned NSF are subject to a $25 administration fee. Application fees include an $11 charge to cover cost for registration audit required by Ontario Fairness Commissioner.
Application for Equivalent Certificate of Registration for OUT OF PROVINCE CERTIFICATE HOLDERS*

* Out-of-province certificate means an active certificate or licence to practise medicine in a province or territory in Canada.

All questions in this application must be answered in full. Please type or print neatly.

1. PHOTOGRAPH OF APPLICANT

One black and white or colour photograph must be affixed above. Photograph must be taken full face and be of passport photograph size and quality. Photograph must be taken within the sixty days prior to submitting this application. Photographs not meeting these specifications will be returned with this application.

The photograph of me attached hereto was taken on: ______ ______ ______

Day Month Year

2. PERSONAL IDENTIFICATION

(a) Full name: _____________________________________________________________

_________________________          ________________________________

Last Name                                                       First Name

_________________________          ________________________________

First Name                                                       Middle Names

(b) Have you ever been known by any other names?    Yes ☐ No ☐

If “Yes,” provide your previous names: ________________________________________________

_________________________          ________________________________

Last Name                                                       First Name

_________________________          ________________________________

First Name                                                       Middle Names

(c) Date of birth: ______ ______ ______

Day Month Year

CPSO or ADM# _____________________

80 College St., Toronto, Ontario, Canada M5G 2E2
(Telephone 1-416-967-2617 or 1-800-268-7096
or Fax 1-416-967-2623)
(d) Sex: Male □ Female □

(e) Have you previously applied for or been issued a licence or certificate of registration by the College of Physicians and Surgeons of Ontario? Yes □ No □

If “Yes,” what was your identification number or your licence or certificate number: _______________________________

3. ADDRESS

Both your mailing address and your primary practice address, with corresponding telephone numbers, must be provided below. The mailing address you provide will be recorded in the College register and will be used as your official mailing address for communications from the College. The primary practice address you provide will also be recorded in the College register and will be available to the public on request. Your mailing address will not be publicly available, unless it is the same as your primary practice address.

If you provide a future mailing or primary practice address, it will replace your present mailing or primary practice address in the College register at the appropriate time.

(a) Present mailing address (include postal code):
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Telephone number: (_______) ____________________ Alternate telephone number: (_______) ____________________
Area Code    Number                                                               Area Code    Number

E-mail address (if available): ________________________________________________________________

(b) Is your present primary practice address the same as your present mailing address? Yes □ No □
If “No,” provide your present primary practice address (include postal code) and your telephone number:
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Telephone number: (_______) ____________________ Alternate telephone number: (_______) ____________________
Area Code    Number                                                               Area Code    Number

E-mail address (if available and if different from above): ________________________________________________________________

(c) Future mailing address (if known and if different from your present mailing address):
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Future telephone number (if known and if different from above): (_______) ____________________
Area Code    Number

Effective date of future mailing address: Day    Month    Year
(d) Future primary practice address (if known and if different from your present primary practice address):

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Future telephone number (if known and if different from above): (_________) ____________________

Area Code    Number

Effective date of future primary practice address:       Day  Month  Year

4. CITIZENSHIP

(a) Are you a Canadian citizen?  Yes ☐  No ☐

If “Yes,” do not answer 4(b).

(b) Do you hold permanent resident status
under the Immigration Act (Canada)?

Yes ☐  No ☐

If “No,” are you now applying for permanent resident status
under the Immigration Act (Canada)?

Yes ☐  No ☐

5. MEDICAL EDUCATION

(a) Name of your medical degree: ____________________________________  Date granted: _______   _______   ______

Day       Month       Year

(b) Name of university or school of medicine granting your medical degree:

_____________________________________________________________________________________________________

(c) Address of university or school of medicine granting your medical degree:

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

(d) Period of time you were enrolled at this university or school of medicine:

From:  _______   _______    to:  _______    _______

Month       Year             Month        Year

(e) Language of instruction at 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: _________________________________________________

(f) Before you graduated from the university or school of medicine named in 5(b), did you
attend any other university or school of medicine to receive part of your medical education?

Yes ☐  No ☐

Complete 5(g) only if you answered “Yes” to 5(f).
6. POSTGRADUATE MEDICAL QUALIFICATIONS

(a) Have you passed, before December 31, 1991, the Medical Council of Canada Qualifying Examination? Yes ☐ No ☐

Examination date: Month __________ Year ________

(b) Have you passed, after December 31, 1991, Part 1 of the Medical Council of Canada Qualifying Examination? Yes ☐ No ☐

Examination date: Month __________ Year ________

(c) Have you passed, after December 31, 1991, Part 2 of the Medical Council of Canada Qualifying Examination? Yes ☐ No ☐

Examination date: Month __________ Year ________

(d) Do you hold the Licentiate Certificate of the Medical Council of Canada (LMCC)? Yes ☐ No ☐

Date of certificate: Month __________ Year ________

(e) Do you hold certification by examination by the Royal College of Physicians and Surgeons of Canada? Yes ☐ No ☐

Specialty: __________________________________________

Certification dates: Day __________ Month __________ Year ________

________________________________________

Day __________ Month __________ Year ________

If “No,” have you passed the written and oral examinations and are now awaiting certification by the Royal College of Physicians and Surgeons of Canada? Yes ☐ No ☐
If “No,” have you received an official assessment that you are now eligible to take,

(i) the written examination of the Royal College of Physicians and Surgeons of Canada?

Yes ☐ No ☐

Expected Examination Date: [ ] [ ]
Month Year

(ii) the oral examination of the Royal College of Physicians and Surgeons of Canada?

Yes ☐ No ☐

Expected Examination Date: [ ] [ ]
Month Year

(f) Do you hold permanent certification, without examination by the Royal College of Physicians and Surgeons of Canada?

Yes ☐ No ☐

Specialty:

________________________________________

Certification date: [ ] [ ] [ ]
Day Month Year

(g) Do you hold certification, by examination by the College of Family Physicians of Canada?

Yes ☐ No ☐

Certification date: [ ] [ ] [ ]
Day Month Year

If “No,” have you passed the examination and are now awaiting certification by the College of Family Physicians of Canada?

Yes ☐ No ☐

If “No,” have you received an official assessment that you are now eligible to take the examination of the College of Family Physicians of Canada?

Yes ☐ No ☐

Expected Examination Date: [ ] [ ]
Month Year

(h) Have you passed, before December 31, 1991, the examinations for the diploma of the National Board of Medical Examiners of the United States of America?

Yes ☐ No ☐

(i) Have you obtained, before December 31, 1991, a score of seventy-five or better on each of Component 1 and 2 of FLEX (the Licensing Examination of the Federation of State Medical Boards of the United States of America)?

Yes ☐ No ☐
7. POSTGRADUATE MEDICAL TRAINING COMPLETED IN CANADA OR THE UNITED STATES OF AMERICA

(a) Internship (PGY 1)

<table>
<thead>
<tr>
<th>Type/Discipline</th>
<th>Medical School/Base Hospital</th>
<th>Date (From/To)</th>
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Was your training performance in all internship rotations and electives rated as satisfactory by your Program Director? Yes ☐ No ☐

If “No,” please attach a comprehensive explanation and identify the Program Director involved.

(b) Residencies (PGY 2-7)

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Medical School</th>
<th>Base Hospital</th>
<th>Dates (From/To)</th>
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<tbody>
<tr>
<td>PGY 2</td>
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<td>PGY 7</td>
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Was your training performance in all residencies rated as satisfactory by your Program Director? Yes ☐ No ☐

If “No,” please attach a comprehensive explanation and identify the Program Director involved.

(c) Clinical or Research Fellowships

<table>
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<tr>
<th>Discipline</th>
<th>Medical School</th>
<th>Base Hospital</th>
<th>Dates (From/To)</th>
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Was your training performance in all clinical or research fellowships rated as satisfactory by your Program Director? Yes ☐ No ☐

If “No,” please attach a comprehensive explanation and identify the Program Director involved.
8. PRACTICE HISTORY

In chronological order, list the names of every jurisdiction where you have practised medicine, including all training appointments, since your graduation from medical school. For each period of practice, please provide the corresponding licence or registration number.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Nature of Practice</th>
<th>Dates (From/To)</th>
<th>Licence or Registration Number</th>
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9. ATTENTION:

The following questions relate to 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 answering the questions and that your answers are consistent with those in any previous application you have made to the College.

For every “yes” answer, 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” answer 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” answer requires Registration Committee review, and that in either case, your honest and frank disclosure will be noted 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 answer 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.

(i) Have you ever applied anywhere for a medical licence and been refused? Yes □ No □

(ii) Have you ever been refused renewal of your medical licence? Yes □ No □

(iii) Are you now applying for a medical licence in any jurisdiction other than Ontario? Yes □ No □

• For every “yes” answer, provide a detailed explanation including all relevant names and dates.
(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.

(i) Regardless of the outcome, have you ever been the subject of any complaint made to a medical licensing authority?
   (Note: 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.)
   Yes □ No □

(ii) Are you now the subject of any complaint made to a medical licensing authority?
   Yes □ No □

(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?
   (Note: Be sure to disclose all medical licensing authority investigations, inquiries or proceedings, including any audits or assessments of your practice.)
   Yes □ No □

(iv) Are you now 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 □ No □

(v) Have you ever had a medical licence revoked, suspended, restricted, limited, or subjected to any other adverse action?
   Yes □ No □

(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 □ No □

(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 □ No □

For every "yes" answer, provide a detailed explanation and include copies of all relevant documents in your possession. Later, the College may require you to arrange for the medical licensing authority or other organization involved to forward further information directly to the College.

For each complaint investigation, provide copies of the complaint, your formal response to the complaint, and the decision and reasons. (For complaints in Ontario, you may omit this step.)

(c) LEGAL ACTIONS, SETTLEMENTS AND COURT FINDINGS

(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 □ No □

(ii) Is there now 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 □ No □

(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 □ No □
(iv) Has a court ever made a finding against you in respect of a civil proceeding, legal action or claim that was in any related to your practice of medicine or your professional activities?  
Yes □  No □

(v) Have you ever been denied professional liability protection or insurance?  
Yes □  No □

- 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.

- For past actions in Canada, contact a Medical Officer at the Canadian Medical Protective Association (CMPA) and authorize a report to be sent to the College that describes the action, your role in the events, and the outcome of the action.

- For current actions in Canada, contact the CMPA or your legal counsel and request a report to be sent 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 to the College that describes the action, your role in the events and the outcome or present status of the action.

(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.

(i) Have you ever pleaded guilty to, or been found guilty of, any offence?  
Yes □  No □

(ii) Have you ever pleaded no contest or made any similar plea to any charge?  
Yes □  No □

(iii) Are there any charges now pending against you for any offence?  
Yes □  No □

(iv) Have you ever been charged or arrested for any offence?  
Yes □  No □

(v) Have you ever entered a diversion program or other resolution process as an alternative to conviction or prosecution for an offence?  
Yes □  No □

- For every "yes" answer, 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.

(e) HOSPITAL PRIVILEGES, PRESCRIBING PRIVILEGES

(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 □  No □

(ii) Have you ever withdrawn an application for privileges at a hospital or other health facility?  
Yes □  No □

(iii) Have you ever voluntarily relinquished or changed your privileges or resigned from a hospital or other health facility, either during or subsequent to 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 □  No □
(iv) Have your privileges ever been revoked, suspended, cancelled, reduced or otherwise changed by a hospital or other health facility?  
Yes □  No □

(v) Have your privileges or legal authority to purchase, prescribe, possess or dispense narcotic, controlled or designated drugs ever been restricted, reduced, withdrawn or voluntarily surrendered?  
Yes □  No □

For every "yes" answer, provide a detailed explanation including all relevant names and dates.

Arrange for the chief of staff, department head or executive officer to send directly to the College a report setting out the circumstances and reasons behind the action.

(f) MEDICAL EDUCATION AND ACADEMIC CONDUCT

(i) Have you ever withdrawn from, or been expelled, suspended, or put on probation or remediation by a medical school?  
Yes □  No □

(ii) Have you ever taken a leave of absence from a medical school or otherwise interrupted your undergraduate medical education?  
Yes □  No □

(iii) Have you ever transferred from one undergraduate medical education program to another?  
Yes □  No □

(iv) Have you ever been the subject of any type of investigation, inquiry or proceeding by a medical school relating to academic misconduct or misconduct of any type?  
Yes □  No □

(v) Have you ever been dismissed, removed, suspended or put on probation or remediation during a postgraduate medical training program?  
Yes □  No □

(vi) Have you ever taken a leave of absence from or otherwise interrupted a postgraduate medical training program?  
Yes □  No □

(vii) Have you ever transferred from one postgraduate training program to another without having fully completed the first program?  
Yes □  No □

(viii) Have you ever withdrawn or resigned from a postgraduate medical training program?  
Yes □  No □

(ix) Have you ever been investigated or sanctioned by any academic, research or regulatory body for misconduct of any type or for any violation of academic policy?  
Yes □  No □

For every "yes" answer, provide a detailed explanation including all relevant names and dates.

For "yes" answers relating to training, 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.

Note to Ontario postgraduate trainees: In most cases, a letter from the Dean regarding your leave of absence or any other change in your postgraduate training status will already be on file with the College, so you should omit this step pending further instructions from the College.

(g) MEDICAL CONDITIONS

In the following questions, "medical condition" includes any mental disorder or illness

(i) Do you now have any medical condition that affects or could affect your ability to practise medicine?  
Yes □  No □

(ii) Have you ever had any medical condition that has affected or could affect your ability to practise medicine?  
Yes □  No □
(iii) Have you ever taken a medical leave of absence from a medical school, a postgraduate medical training program or any professional position or employment?  

Yes ☐ No ☐

(iv) Do you now have a communicable disease or are you a carrier, whether asymptomatic or otherwise, of an infectious agent of a communicable disease?  

Yes ☐ No ☐

(v) Are you now abusing, dependent on, or addicted to alcohol or a drug?  

Yes ☐ No ☐

(vi) Are you being treated for abuse of, dependence on, or addiction to alcohol or a drug?  

Yes ☐ No ☐

(vii) Have you ever abused, been dependent on, or addicted to alcohol or a drug?  

Yes ☐ No ☐

(viii) Have you ever been treated for abuse of, dependence on, or addiction to alcohol or a drug?  

Yes ☐ No ☐

• For every “yes” answer, provide a detailed explanation.

• 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.

(h) GENERAL

(i) Have you ever ceased or interrupted your medical practice for any reason for six months or longer?  

Yes ☐ No ☐

(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 ☐ No ☐

(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 ☐ No ☐

• For every “yes” answer, provide a detailed explanation.
(i) 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 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.

5. 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.

Dated: ______ ______ ______  

Day Month Year  
_______________________________________________  
Signature of Applicant

IMPORTANT: Ensure that you complete the declaration on the following page. Your declaration must be made before a Commissioner for Oaths, Lawyer or Notary Public.
WARNING

Subsections 92 (1) and (2) of the Health Professions Procedural Code provide: (1) 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; (2) Every person who knowingly assists a person in committing an offence under subsection (1) is guilty of an offence and on conviction is liable to a fine of not more than $25,000.

DECLARATION

I, ________________________________
Full Name

of the ________________________________ of ________________________________
Type of Municipality Name of Municipality

in the ________________________________ of ________________________________
Province or State Name of Province or State

hereby declare the following:

1. I am the person making application for a certificate of registration to practise 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 the sixty days 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.

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.

Declared before me in the ________________________________ of ________________________________
City, Town, County

in the ________________________________ of ________________________________
Province or State

this day of ________________________________ 200 — .

______________________________________________________________
Signature of Applicant

______________________________________________________________
Signature of a Commissioner for Oaths, Lawyer or Notary Public

Print Name and Address of Commissioner, Lawyer or Notary Public:
______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Seal, stamp or card of Commissioner, Lawyer or Notary Public must be affixed here.
More than 70,000 physicians across Canada already have a Medical Identification Number for Canada (MINC).

What are you waiting for?

It’s free!
MINC program operating costs are covered by licensing fees paid by user organizations.

It’s easy!
Go to Section L on your 2010 CPSO Registration Renewal form and choose ‘Yes’ to confirm your consent.

CPSO staff will work with the MINC program to coordinate issuance of your MINC after your renewal is processed.

For more information:
Call the CPSO office at (416) 967-2603 or 1-800-268-7096, ext. 603 or visit www.minc-nimc.ca

Establish your identity in the Canadian medical system!

The MINC program is endorsed by:

* Throughout this brochure, the MINC acronym has been used in place of the organization’s formal name of MINC#NIMC.

April 2010
Numbers, numbers and more numbers ...

From the time you start medical school until the time you leave practice, you will be assigned dozens of different identification numbers.

Your university, regulatory college, medical association, provincial government billing agency and other administrative organizations each have a distinct way to identify you in their databases.

These numbers are different from province to province and from one organization to another. Unfortunately, few of these databases can talk to each other, making it difficult to quickly and accurately verify a physician’s identity. There are simply too many variables involved and mistaken identity can occur.

To resolve this problem, a national, unique, lifetime identifier has been developed - the Medical Identification Number for Canada (MINC).

With your consent, a MINC number will be created for you. Once you have your number, you keep it for life. No matter where you practise medicine in Canada, your number will go with you – providing an easy and reliable way to confirm your identity.

What’s in it for me?
The benefits of the MINC program will be realized mainly by medical regulatory, research or administrative organizations.

However, if you have a MINC, it will be easier for regulatory and administrative bodies in the medical system to confirm your identity.

This means less chance of mistaken identity and potentially faster processing of your application to any organization licensed to use MINC numbers.

Who has access to my number?
Only organizations that have entered into a licensing agreement with MINC have access.

These include Canada’s medical regulatory colleges, the Medical Council of Canada and the Canadian Medical Protective Association; and may include professional associations, medical credentialing and educational bodies.

Who operates MINC?
MINC is jointly owned and paid for by the Federation of Medical Regulatory Authorities of Canada (FMRAC) and the Medical Council of Canada (MCC).

Questions?
Call the CPSO at (416) 967-2603, 1-800-268-7096, ext. 603, or go to www.minc-nimc.ca