The College of
Physicians and Surgeons of Ontario
Applications and Credentials Department
80 College Street, Toronto, Ontario, Canada M5G 2E2
Telephone: 416-967-2617; 1-800-268-7096 (In Canada only)

APPLICATION FOR A CERTIFICATE OF REGISTRATION AUTHORIZING
SUPERVISED SHORT DURATION PRACTICE

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

Affix Photograph Here

CPSO Registration or File Number _____

1. PERSONAL DETAILS

a) One black and white or colour photograph must be affixed above. Photograph must be full face, of passport size and quality, and taken within six months of submitting this application.
The photograph of me attached hereto was taken on: _____/_____/_____
Day Month Year

b) _____
Last Name

_____ _____
First Name Middle Names

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

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

_____ _____
First Name Middle Names

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

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

e) Gender: Male ☐ Female ☐

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

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

Yes ☐ No ☐ If "No", are you now applying for Permanent Resident Status in Canada? Yes ☐ No ☐

h) Do you hold an employment authorization (work permit) under the IRPA which enables you to undertake the appointment for a supervised short duration appointment identified below?

Yes ☐ No ☐

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

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

Yes ☐ No ☐

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

2. SUPERVISED SHORT DURATION APPOINTMENT DETAILS

a) Expected commencement and completion dates for the Ontario supervised short duration appointment, not exceeding thirty days in duration:

Start Date: _____/_____/_____ (Day/Month/Year) End Date: _____/_____/_____ (Day/Month/Year)

b) Name of Ontario medical school, public hospital, psychiatric facility or Crown Agency at which you have an appointment:

_____

c) Name, title and contact information of the member of this College, holding an Independent Practice certificate of registration, who undertakes to supervise you and will remain responsible for providing continuing care to patients attended by you:

Dr. _____ CPSO Registration Number: _____

Title: _____

Telephone Number: (____) _____ - _____ Email Address: _____

d) Name and title of the primary contact person at an Ontario location, if different from physician named in 2(c):

_____

Telephone Number: (____) _____ - _____ Email Address: _____

3. CONTACT DETAILS

The mailing address you provide will be used as your official mailing address for communications from the College. The appointment address you provide will also be recorded in the College register and will be available to the public for the duration of your appointment in Ontario. **As part of the application process, you may receive information pertaining to your application that is confidential. It is therefore your responsibility to ensure that your email address is secure.**

a) Email Address: _____

b) Present Mailing Address:

_____

_____

Telephone Number: (____) _____ - _____

c) Address of Ontario medical school, public hospital, psychiatric facility or Crown Agency at which you have an appointment requiring you to hold a certificate of registration authorizing Supervised Short Duration Practice:

_____

_____

Telephone Number: (____) _____ - _____

4. UNDERGRADUATE MEDICAL EDUCATION

a) Qualification Title of your Medical Degree:

_____

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

_____

_____

_____

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

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

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

e) Your native language is: _____

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

English Yes ☐ No ☐

French Yes ☐ No ☐

Other Yes ☐ No ☐

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

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

Yes ☐ No ☐

If "Yes", please specify:

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

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

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

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

_____

_____

_____

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

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

5. POSTGRADUATE MEDICAL QUALIFICATIONS

a) Medical Council of Canada Examinations

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

b) Equivalent to Medical Council of Canada Qualifying Examinations

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

c) Acceptable Alternative to Medical Council of Canada Qualifying Examinations

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

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

Yes ☐ No ☐

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

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

Yes ☐ No ☐

Examination Date: _____ /_____
Month Year

d) Royal College of Physicians and Surgeons of Canada Qualifications

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

Yes ☐ No ☐

Certification Date: _____ /_____
Month Year

Speciality: _____

Yes ☐ No ☐

Sub-speciality, if applicable: _____

Certification Date: _____ /_____
Month Year

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

Yes ☐ No ☐

Expected Examination Date:
_____ /_____
Month Year

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

Yes ☐ No ☐

Specify Route to Certification: _____

Certification Date: _____ /_____
Month Year

Speciality: _____

e) College of Family Physicians of Canada Qualifications

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

Yes ☐ No ☐

Certification Date: _____ /_____
Month Year

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

Yes ☐ No ☐

Certification Date: _____ /_____
Month Year

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

Yes ☐ No ☐

Expected Examination Date:
_____ /_____
Month Year

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

Yes ☐ No ☐

Certification Date: _____ /_____
Month Year

Specify Route to Certification: _____

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

Yes ☐ No ☐

f) Collège des médecins du Québec Qualifications

Do you hold a specialist certificate, obtained by examination, by the Collège des médecins du Québec? Yes ☐ No ☐

Discipline: _____ Certification Date: _____ /_____ Month Year

If "No", specify route to certification: _____

g) Qualifications by the American Board of Medical Specialties

Do you hold certification by the American Board of Medical Specialities? Yes ☐ No ☐

Certification Date: _____ /_____ Month Year

Speciality: _____ Expiry Date: _____ /_____ Month Year

Yes ☐ No ☐

Sub-speciality, if applicable: _____ Certification Date: _____ /_____ Month Year

Expiry Date: _____ /_____ Month Year

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

Expected Examination Date: _____ /_____ Month Year

h) Other Qualifications

Are you certified as a medical specialist by an organization outside Canada or United States that certifies medical specialists? Yes ☐ No ☐

Certification Date: _____ /_____ Month Year

Name of Organization Granting the Medical Specialist Qualification:

_____

Discipline:_____

Are you certified as a medical sub-specialist by an organization outside Canada or United States that certifies medical specialists? Yes ☐ No ☐

Certification Date: _____ /_____ Month Year

Name of Organization Granting the medical sub-specialist qualification:

_____

Discipline: _____

6. POSTGRADUATE MEDICAL TRAINING COMPLETED IN CANADA OR UNITED STATES

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

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

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

(b) Clinical and Clinical-Research Fellowships

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

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

7. POSTGRADUATE MEDICAL TRAINING COMPLETED OUTSIDE CANADA OR UNITED STATES

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

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

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

b) Clinical and Clinical-Research Fellowships

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

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

8. PRACTICE HISTORY

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

Jurisdiction (Province, State or Country)	Nature/Type of Postgraduate Training and Medical Practice	From Month/Year	To Month/Year	Licence Number
		/	/	
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9. BREAKS IN MEDICAL TRAINING AND PRACTICE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) APPLICATIONS TO MEDICAL LICENSING AUTHORITIES

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

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

(i)	Have you ever applied anywhere for a medical licence and been refused?	Yes ☐ No ☐
(ii)	Have you ever been refused renewal of your medical licence?	Yes ☐ No ☐
(iii)	Are you currently applying for a medical licence in any jurisdiction other than Ontario?	Yes ☐ No ☐

b) ACTIONS BY MEDICAL LICENSING AUTHORITIES

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

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

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

(i)	**<u>Regardless of the outcome</u>**, have you ever been the subject of any complaint made to a medical licensing authority? *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 currently the subject of any complaint made to a medical licensing authority?	Yes ☐ No ☐
(iii)	Have you ever been the subject of **<u>any type</u>** 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? *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 currently the subject of **<u>any type</u>** 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 ☐

c) LEGAL ACTIONS, SETTLEMENTS AND COURT FINDINGS

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

(i) Has there ever been any civil proceeding, legal action, insurance or other claim that was in any way related to your practice of medicine or your professional activities?	Yes ☐ No ☐
(ii) Is there currently any civil proceeding, legal action, insurance or other claim that is in any way related to your practice of medicine or your professional activities?	Yes ☐ 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 professional activities?	Yes ☐ No ☐
(v) Have you ever been denied professional liability protection or insurance?	Yes ☐ No ☐

d) CHARGES AND CONVICTIONS

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

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

(i)	Have you ever pleaded guilty to, or been found guilty of, any offence?	Yes ☐ 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 ☐

e) PRIVILEGES AND PROFESSIONAL EMPLOYMENT

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

(i)	Have you ever been denied privileges or been denied appointment or reappointment to the medical staff of a hospital or other health facility?	Yes ☐ 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, health facility, or any other place of employment during, subsequent to or in expectation of, an inquiry, investigation or review that was in any way related to your professional conduct, competence, capacity, or any other aspect of your medical practice?	Yes ☐ 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 surrendered?	Yes ☐ No ☐
(vi)	Are you now or have you ever been the subject of any type of investigation, inquiry, review or action by a hospital, health facility, or any other place of employment relating to your professional conduct, competence, capacity, or any aspect of your medical practice? *Be sure to disclose all such matters,* ***regardless of outcome****.*	Yes ☐ No ☐

f) MEDICAL EDUCATION AND ACADEMIC CONDUCT

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

Undergraduate Medical Education

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

Postgraduate Medical Education

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

General

(xiii)	Have you ever been investigated or sanctioned by any academic, research or medical educational body of any type for any violation of academic policy?	Yes ☐ No ☐

g) MEDICAL CONDITIONS (GENERAL)

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

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

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

h) MEDICAL CONDITIONS (BLOOD BORNE VIRUSES)

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

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

i) GENERAL

- *For every "Yes" answer, provide a detailed explanation.*

(i)	Have ever ceased, interrupted or delayed commencement of postgraduate training or 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 ☐

j) UNDERSTANDING, AGREEMENT and THIRD-PARTY AUTHORIZATION

1) I understand that I will be deemed by the College of Physicians and Surgeons of Ontario (the "College") not to have satisfied the requirements and qualifications for a certificate of registration if, in connection with this application or any past application, I have made a false or misleading representation, either because of what was stated or left unstated.

2) I understand that any certificate of registration that results from this application is void and is deemed to have always been void if I have made any false or misleading representation or declaration on or in connection with this application, whether by commission or omission.

3) I agree that during the course of this application I will immediately notify the College in writing of anything that renders any response to the questions in this application, although true and complete when made, no longer true and complete. I understand that failure to notify the College of any such thing may void any certificate of registration that results from this application.

4) I understand that the College's registration and credentialing requirements are subject to change and that any such changes, including possible updates during the course of this application may apply to me. I understand that the maximum term of validity for most supporting source credentialing documents is six months from the date of issuance. I understand that if my application remains incomplete or inactive for one year, it will be considered withdrawn**.**

5) I understand that the submission of this application for registration to the College and any registration with the College that may result, shall constitute and operate as authorization by me for the College to make such inquiries about me of any kind that it considers appropriate in connection with this application and to disclose information about me to other medical licensing authorities, federations of licensing authorities, hospitals and other institutions to which I apply for appointment.

6) I understand that this Understanding, Agreement and Third-party Authorization is valid commencing on the date subscribed below and that this Understanding, Agreement and Third-party Authorization will remain in force and effect during the course of this application and until I no longer hold a certificate of registration issued by the College.

_____
Print Full Name of Applicant

_____
Signature of Applicant

Date: _____/ _____ / _____
Day Month Year

11. PROFESSIONAL LIABILITY PROTECTION

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

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

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

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

a) Professional Liability Protection – Declaration by Applicant

Not Applicable ☐

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

1. I currently hold professional liability protection that extends to all areas of my practice in Ontario. My professional liability protection is provided through:

   (a) Membership in the Canadian Medical Protective Association (CMPA), under membership number:

   _____, or
   CMPA #

   (b) A policy of professional liability insurance issued by a company licensed to carry on business in Ontario that provides coverage of at least $10,000,000, namely

   _____, _____, or
   Name of Company Policy Number

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

2. I understand that after I am registered with the College and have identified the provider of my professional liability protection, the College may inquire with the provider regarding whether I hold professional liability protection in compliance with s. 50.2 of the College by-law, and I hereby consent to disclosure of this information to the College by the provider of my professional liability protection.
3. I understand that I must have available in my office, in written or electronic form, for inspection by the College, evidence that I hold professional liability protection.
4. I understand that my registration with the College will expire when I no longer hold professional liability protection.
5. I understand that before each annual renewal of my College registration, I must sign a declaration that I hold professional liability protection.
6. I understand that it is an offence under s. 92 of the *Health Professions Procedural Code* to make a false representation for the purpose of having a certificate of registration issued.
7. I understand that I will be deemed not to have satisfied the requirements and qualifications for a certificate of registration if I have made a false or misleading representation in this Declaration.

_____
Print Full Name of Applicant

_____
Signature of Applicant

Date: _____/ _____ / _____
Day Month Year

b) Professional Liability Protection – Undertaking by Applicant

Not Applicable ☐

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

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

_____
Print Full Name of Applicant

_____
Signature of Applicant

Date: _____/ _____ / _____
Day Month Year

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I have read and understand the above information, and consent to the College of Physicians and Surgeons of Ontario's release of the Core Information to MINC#NIMC for the purpose of generating a MINC number that will be permanently assigned to me or checking my existing Core Information with MINC#NIMC.	**Yes** ☐
I further consent to MINC#NIMC storing the MINC number in its database and disclosing the MINC number to Prime and Licensed Users, as outlined above. I also understand that I may withdraw my consent to MINC at any time, by written notice to MINC#NIMC.	**No** ☐

_____
Print Full Name of Applicant

_____ Date: _____/ _____ / _____
Signature of Applicant Day Month Year

13. DECLARATION

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

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

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

I, Dr. _____
Full Name of Applicant

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

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

hereby declare the following:

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

_____
Print Full Name of Applicant

_____
Signature of Applicant

Date: _____/ _____ / _____
Day Month Year