APPLICATION FOR PHYSICIAN REGISTRATION

COLLEGE OF PHYSICIANS AND SURGEONS OF NEW BRUNSWICK

DEPARTMENT OF HEALTH

1	Surname	Given Names	Male Female	Date of Birth Y M D
2	Previous Names	Place of Birth (City / Town / Country)		
3	Citizenship	E-mail address		
4	Language Fluency English French Other (____________, ____________, ____________, ____________)			Correspondence in English French
5	Current Mailing Address			
		Postal Code	Telephone ( )	
6	Intended Practice Location (if known)	Intended Start Date		
		Postal Code	Telephone ( )	
7	Location of Previous Practice(s) with dates			

BASIC MEDICAL EDUCATION - MD OR EQUIVALENT

8	Date of Graduation Y M	Medical School

SPECIALTY OR FAMILY PRACTICE RESIDENCY

9	Specialty			
10	Location & Dates			
11	Certification Body			
	RCPSC Date: ______________ (MM/DD/YY)	CFPC Date: ______________ (MM/DD/YY)	CMQ Date: ______________ (MM/DD/YY)	Other ______________ Date: ______________ (MM/DD/YY)

DECLARATION

REFERENCES AND CONTACT INFORMATION

Names and contact information of three (3) physicians of recent acquaintance.

1) ____

2) ____

3) ____

PERSONAL INFORMATION (Yes or No. If yes, specify)

1	Have you **ever** been treated for any illness or disability whether physical or mental, and including blood-borne pathogens, which could **in any way** potentially affect your practice of medicine?
2	Have you **ever** been treated for alcohol or drug abuse?
3	Have you **ever** been refused medical licensure or had your medical license, registration certificate or right to practise in any jurisdiction revoked, suspended or restricted **in any way**?
4	Have you **ever** had your hospital privileges revoked, suspended, or restricted **in any way**?
5	Have you **ever** had an internship, residency, hospital or other institutional appointment prematurely terminated or interrupted?
6	**Tgi ctf nguuqhvj g qwveqo g**, have you **ever** been charged or convicted of a criminal or similar offence?
7	Have you **ever** had your right to prescribe narcotics or any other drug restricted **in any way**?
8	**Tgi ctf nguuqhvj g qwveqo g**, are you **presently** or have you **ever** been subject to an allegation, complaint, or investigation **for any reason** whatsoever by a medical licensing authority?
9	Are you aware of **any** inquiry likely to be made by any authority, whether licensing, hospital or otherwise, with respect to your conduct, personal behaviour or competence?
10	Regardless of the outcome, have you **ever** been sued for malpractice?
11	Have you **ever** had the right to bill restricted or removed by a health care paying agency?
12	Are you aware of **any** other issue which may be relevant to this application?

DECLARATION

I certify that the statements made by me in this application are true and complete to the best of my knowledge. I am aware that misrepresentation or falsification may result in rejection of my application or withdrawal of registration.

I authorize and direct the College of Physicians and Surgeons of New Brunswick to provide and/or release to any other Licensing Authority, Hospital, Institution, or other entity, that I may designate, any and all information the College of Physicians and Surgeons in its discretion deems relevant.

I further authorize and direct any other Licensing Authority, hospital, institution, law enforcement agency, examining or certifying agency or person, to release all information requested by the College of Physicians and Surgeons of New Brunswick. And I further agree to indemnify and hold same harmless from and against any and all manner of actions, claims, or demands by any third party arising out of or in any way connected to the request for information made by the College of Physicians and Surgeons of New Brunswick.

I further authorize the College of Physicians and Surgeons of New Brunswick to transmit to MINC the information required to create my MINC. This information will be used by MINC to authenticate my identity with licensed users.

Date____ ____

Signature of applicant

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