THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

READ INSTRUCTIONS CAREFULLY:

DO NOT SEND INCOMPLETE FORM BACK TO THIS COLLEGE.

IT IS YOUR RESPONSIBILITY TO HAVE THIS FORM COMPLETED BY ALL MEDICAL LICENSING 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)

_____
Licence Number

_____
Signature of Applicant

_____
Date

_____
_____
_____
_____
Applicant's Address

*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 (month / year)	Date Expired or Cancelled (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.