COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

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Registration Waiver

REGISTRANT INFORMATION

Name: _____ CPSID: _____

AUTHORIZATION

I, _____ acknowledge and agree that I have been granted registration by the College of Physicians and Surgeons of British Columbia ("the College") on the express condition that it will be immediately revoked if:

(a) my references, certificates of professional conduct from other medical licensing authorities, or other documents are not acceptable to the registrar of the College.

(b) the following outstanding document(s) are not received by the College within six (6) weeks from the date of registration and the reason(s) for such non-receipt are not acceptable to the registrar:

1. Medical degree: _____
2. LMCC: _____
3. Specialty: _____
4. Postgraduate training: _____
5. Certificate(s) of professional conduct: _____
6. Letters of reference: _____
7. Identification/passport: _____
8. Criminal records: clear Criminal Records Check
9. Physiciansapply.ca verification: _____
10. APMLE: _____
11. Primary source verification: _____
12. Other/miscellaneous: _____

I acknowledge and agree that I will be granted registration by the College on the express condition that it will be immediately revoked if criminal records check documents confirming a clear criminal record are not received by the College within six (6) weeks from the date of registration and the reason(s) for such non-receipt are not acceptable to the registrar, or the outstanding document received is not satisfactory to the registrar.

(c) the documentation from physiciansapply.ca is not received within a period of four (4) months from the date of registration, or other such time deemed acceptable to the registrar, and the reasons for such non-receipt are not acceptable to the registrar.

SIGN OFF

Signature: _____ Date: _____