

ATTACH
PASSPORT STYLE
PHOTOGRAPH
TAKEN WITHIN
THE LAST 90 DAYS

APPLICATION FOR REGISTRATION – Visiting Physician

OFFICE USE ONLY	CPSID:
	ACCT:

Please PRINT your responses clearly and completely.

If you have any questions, contact the registration department at the College for assistance. 604-733-7758 or 1-800-461-3008 (toll-free in BC)

Surname

Given Name(s)

Surname at Birth/Maiden Name

If different from above.

Shortened Name(s) Due to space constraints, at times your given names must be shortened. Please indicate how your name should be displayed if different from above.

Current Mailing Address

Suite/Unit	Street Address	City
Province/State	Country	Postal Code/Zip Code

Mailing Address in British Columbia

Suite/Unit	Street Address	City
Province/State	Country	Postal Code/Zip Code

Current Contact Information

Phone	Fax	Email
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Date of Birth

YYYY	MM	DD
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Gender M F

Legal Status Canadian Permanent Resident (Landed Status) Work Permit Other _____

Languages Spoken English Other Languages _____

Please list the languages other than English in which you are fluent and competent to conduct your practice.

ENGLISH PROFICIENCY

All applicants must demonstrate English language proficiency in accordance with the College's English Language Proficiency Policy in effect as of January 25, 2017 and complete the English Language Proficiency Information Required form included with the application package.

DEGREE

Medical Degree Degree of Osteopathic Medicine Date Granted YYYY MM DD

University, College or Medical School Granting Medical Degree

Name of School	Province/State	Country
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CERTIFICATION

Effective Date (YYYY-MM-DD)

College of Family Physicians of Canada (CFPC) Yes No _____

Certification by the Royal College of Physicians and Surgeons of Canada Yes No _____

Other Yes No _____

MINC Number (if available) _____

PERSONAL INFORMATION

Provide a written explanation for any question answered **YES**.

All questions in the Personal Information section **must** be answered. A **written explanation** must be given for all **affirmative** answers. Such information is **confidential** to the College of Physicians and Surgeons of British Columbia.

1. Do you have a physical, cognitive or mental health condition that is negatively impacting your medical practice, or is reasonably likely to negatively impact your medical practice in the future, that has not been previously reported to the College of Physicians and Surgeons of BC? Yes No
2. Have you ever had, or been advised by a health-care professional that you have had, a physical, cognitive or mental health condition that, were it to recur, would be reasonably likely to negatively impact your medical practice in the future, that has not been previously reported to the College of Physicians and Surgeons of BC? Yes No
3. Do you perform or assist in performing exposure-prone procedures? Yes No
Exposure-prone procedure examples: digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health-care worker's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site (e.g. during major abdominal, cardiothoracic, vaginal and/or orthopedic operations); repair of major traumatic injuries; manipulation, cutting or removal of any oral or perioral tissue, including tooth structures.
Reference: SHEA https://www.shea-online.org/images/guidelines/BBPathogen_GL.pdf
 - a. If yes, have you ever tested positive for a blood-borne pathogen such as hepatitis B virus (HBV), hepatitis C virus (HCV) or human immunodeficiency virus (HIV) that you have not previously reported to the College of Physicians and Surgeons of BC? Yes No
4. Have you ever had your health authority or hospital privileges revoked, suspended or restricted in any way other than for non-completion of medical records, or have you ever surrendered or altered your privileges as a result of potential revocation, suspension or restriction? Yes No
5. Have you ever had your non-hospital medical and surgical facility privileges revoked, suspended or restricted in any way other than for non-completion of medical records, or have you ever surrendered or altered your privileges as a result of potential revocation, suspension or restriction? Yes No
6. Have there been any disciplinary actions, complaint investigations, practice reviews, formal reviews, or other proceedings initiated, pending or completed against you by a licensing authority other than the College of Physicians and Surgeons of BC? Yes No
7. Have there been any disciplinary actions, complaint investigations, practice reviews, formal reviews, or other proceedings initiated, pending or completed against you by a hospital? Yes No
8. Have you ever been disciplined or entered into a formal agreement or given a formal undertaking to a licensing authority, other than the College of Physicians and Surgeons of BC, to address a discipline matter, investigation, practice review, formal review or other proceeding? Yes No
9. Have you ever been charged with a criminal or similar offence but not convicted? Yes No
10. Have you ever been convicted of a criminal or similar offence? Yes No
11. Has any civil court ever made a finding against you or have you entered into an out-of-court settlement relevant to your medical practice? Yes No

LICENCE TO PRACTISE MEDICINE

Please indicate where you are currently licensed to practise medicine.

AUTHORIZATION OF APPLICANT

I hereby certify that the information provided in this application is true. If, prior to the issuance of a licence, there is any change in the information provided in this application, I will immediately inform the College and provide details of that change.

I hereby authorize the College of Physicians and Surgeons of British Columbia to make such inquiries about me as it considers appropriate in connection with this application.

I further authorize any licensing authority or hospital, undergraduate or postgraduate training program or reference or individual to disclose to the College of Physicians and Surgeons of British Columbia information otherwise confidential and I waive any right of disclosure of same to me and agree that communication between the College and the discloser shall be privileged.

I further authorize the College of Physicians and Surgeons of British Columbia to revoke any licence issued to me if it subsequently appears that I have, by omission or commission, given false or misleading information in respect of any question on this application form or have failed to notify the College prior to licensure of any change in the information provided.

Dated _____ Signature _____

The information in this application form is collected under the authority of the *Health Professions Act*, RSBC 1996, c.183. The information provided will be used to process your application for registration and for all purposes pertaining to your registration with the College of Physicians and Surgeons of British Columbia. If you have any questions about the collection and use of this information, please contact the College registration department at 300-669 Howe Street, Vancouver BC V6C 0B4, or call 604-733-7758 or 1-800-461-3008 (toll-free in BC).