THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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REGULATED ASSOCIATE MEMBER PHYSICIAN ASSISTANT - FULL APPLICATION FORM

In accordance with the Human Rights Act of Manitoba, you may, but are no longer required to include a photograph. However, if your registration is accepted, you will be required to supply a photograph and other identification to establish that you are the person represented by the documents, along with proof of any change of name other than that upon which you seek to be registered.

(1) **Applications are valid for six months from the date filed.** *An update application will be required if your registration is not issued within that period.*
Submit this application and the $330.00 documentation fee. **FEES ARE NON-REFUNDABLE and are subject to change without notice.**

(2) Read the application instructions and this application carefully. Answer ALL questions completely. If additional space is needed for an answer, attach a separate typed sheet marked as an "Addendum to Application" and sign it.

FULL LEGAL NAME: *(last, first, middle)*		
OTHER NAMES YOU HAVE BEEN KNOWN BY:		DATE OF BIRTH: *(month, day, year)*
HOME ADDRESS: (Street, City, State/Province)		☐Use as mailing address?
PRACTICE ADDRESS:		☐Use as mailing address?
E-MAIL ADDRESS:		
PHYSICIAN ASSISTANT TRAINING PROGRAM: (Name of Program, City, State/Prov)		DIPLOMA DATE:
NCCPA CERT. DATE **OR** FUTURE EXAM DATE:	NCCPA NUMBER:	CURRENT/PREVIOUS BRANCH OF MILITARY:

LIST ALL HEALTH-RELATED LICENCES/CERTIFICATES YOU HAVE APPLIED FOR, HAD, OR STILL HAVE:

TYPE OF LICENCE	STATE/PROV OR COUNTRY	DENIED	GRANTED	DATE	NUMBER	CURRENT YES	CURRENT NO

1. EDUCATION, EMPLOYMENT, AND OTHER ACTIVITIES

In the format shown below, attach a detailed curriculum vitae (employment, school, vacation, unemployment, moving, etc.). **DO NOT** leave a gap of more than two weeks or you will be asked to provide information in writing for these time periods. Employment verification will be required for all medically related employment. Include the name of an immediate supervisor or human resources department contact.

Name & Mailing Address of Employer and/or Description of Activity (school, unemployed, travel, vacation, etc.)	Your Title	From (mth/day/yr)	To (mth/day/yr)

2. REFERENCES (Please Print)

List three persons (none of whom is related to you) with recent professional/educational knowledge of you. Include full e-mail or postal address. Incomplete addresses will delay processing.

	Name	E-mail or Mailing Address
1.	_____	_____
2.	_____	_____
3.	_____	_____

WHERE IN MANITOBA DO YOU INTEND TO PRACTISE:

Location/Clinic/Office Address _____
(full mailing address)

Expected Start Date _____

3. PERSONAL INFORMATION

An applicant for registration must disclose the following information about himself or herself and his or her practice of medicine *or of any other profession.*

INFORMATION ABOUT LICENCES, PERMITS AND APPLICATIONS

1. HAVE YOU EVER HAD AN APPLICATION FOR A MEDICAL LICENCE, CERTIFICATE OF REGISTRATION, OR PERMIT TO PRACTISE, REJECTED, REFUSED OR DENIED?

   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

2. HAVE YOU EVER HAD AN APPLICATION TO PRACTISE A HEALTH PROFESSION OR ANY OTHER REGULATED PROFESSION OR OCCUPATION IN CANADA OR ELSEWHERE REJECTED, REFUSED OR DENIED?
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

3. HAVE YOU EVER BEEN REFUSED RENEWAL OF A MEDICAL LICENCE, CERTIFICATE OF REGISTRATION OR PERMIT TO PRACTISE?
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

4. HAVE YOU EVER HAD A MEDICAL LICENCE, CERTIFICATE OF REGISTRATION OR PERMIT TO PRACTISE:
   a. REVOKED:
      ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
   b. SUSPENDED:
      ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

c. RESTRICTED IN ANY WAY:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
d. SUBJECTED TO CONDITIONS OF ANY KIND:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
e. LIMITED IN ANY WAY:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
f. SUBJECTED TO ANY OTHER ADVERSE ACTION:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

5. HAVE YOU EVER HAD YOUR AUTHORITY TO PRACTISE MEDICINE OR ANY OTHER HEALTH PROFESSION:
a. REVOKED:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
b. SUSPENDED:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
c. RESTRICTED IN ANY WAY:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
d. SUBJECTED TO CONDITIONS OF ANY KIND:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
e. LIMITED IN ANY WAY:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
f. SUBJECTED TO ANY OTHER ADVERSE ACTION:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

MEDICAL REGULATORY AUTHORITIES ACTIONS RELATED TO PROFESSIONAL CONDUCT AND COMPETENCE

6. ARE YOU NOW THE SUBJECT OF A COMPLAINT TO OR REFERRAL FOR INVESTIGATION TO A MEDICAL LICENSING OR REGULATORY AUTHORITY?
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

7. HAVE ANY PAST COMPLAINTS OR REVIEWS OR OTHER PROCEEDINGS RESULTED IN ANY OF THE FOLLOWING ACTIONS BY A MEDICAL LICENCING OR REGULATORY AUTHORITY. INDICATE ALL THAT APPLY.
a. AN INVESTIGATION:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
b. A DISCIPLINARY PROCEEDING:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
c. AN ASSESSMENT OF YOUR CONDUCT, COMPETENCE, CAPACITY OR FITNESS TO PRACTISE:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
d. AN AUDIT OF YOUR PRACTICE:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
e. AN ASSESSMENT OF YOUR PRACTICE:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
f. WITH SPECIAL SUPPORT MEASURES:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

8. ARE YOU CURRENTLY SUBJECT TO AN INVESTIGATION, A REVIEW OR ANY OTHER PROCEEDING IN RELATION TO ANY OF THE FOLLOWING (WHETHER ARISING FROM A COMPLAINT OR OTHERWISE):
a. YOUR CONDUCT (PROFESSIONAL, UNBECOMING OR MISCONDUCT):
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
b. YOUR COMPETENCE:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
c. YOUR CAPACITY:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
d. YOUR FITNESS TO PRACTISE:
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

9. ARE YOU CURRENTLY SUBJECT TO AN INVESTIGATION OR PROCEEDING RELATING TO YOUR CONDUCT, COMPETENCE, CAPACITY OR FITNESS TO PRACTICE A HEALTH PROFESSION OR ANY OTHER REGULATED PROFESSION OR OCCUPATION IN CANADA OR ELSEWHERE?
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

10. HAS THERE EVER BEEN AN INVESTIGATION, A REVIEW OR ANY OTHER PROCEEDINGS IN RELATION TO ANY OF THE FOLLOWING (WHETHER ARISING FROM A COMPLAINT OR OTHERWISE):
a. YOUR CONDUCT (PROFESSIONAL, UNBECOMING OR MISCONDUCT):
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

b. YOUR COMPETENCE:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
c. YOUR CAPACITY:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
d. YOUR FITNESS TO PRACTISE:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

11. HAVE YOU EVER BEEN THE SUBJECT OF A REVIEW OF YOUR CONDUCT, COMPETENCE, CAPACITY OR FITNESS TO PRACTISE A HEALTH PROFESSION OR ANY OTHER REGULATED PROFESSION OR OCCUPATION IN CANADA OR ELSEWHERE, WHETHER ARISING FROM A COMPLAINT OR OTHERWISE?
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

12. HAVE YOU EVER BEEN THE SUBJECT OF A FINDING OF ANY OF THE FOLLOWING BY A MEDICAL REGULATORY AUTHORITY:
    a. PROFESSIONAL MISCONDUCT:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. CONDUCT UNBECOMING:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. INCOMPETENCE:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    d. AN INCAPACITY OR LACK OF FITNESS TO PRACTISE:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

13. HAS THERE EVER BEEN A FINDING OF CONDUCT UNBECOMING, PROFESSIONAL MISCONDUCT OR INCAPACITY OR LACK OF FITNESS TO PRACTISE A HEALTH PROFESSION OR ANY OTHER REGULATED PROFESSION OR OCCUPATION IN CANADA OR ELSEWHERE?
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

14. HAS YOUR NAME BEEN REMOVED, AS A RESULT OF PROFESSIONAL MISCONDUCT OR ANY OTHER CAUSE, THAT IS RELEVANT TO YOUR SUITABILITY TO PRACTISE MEDICINE, FROM THE REGISTER OF PERSONS AUTHORIZED TO ENGAGE N THE PRACTICE OF MEDICINE, OR ANY OTHER HEALTH PROFESSION IN CANADA OR ELSEWHERE?
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

15. IN CONNECTION WITH ANY COMPLAINT, INQUIRY, INVESTIGATION OR OTHER PROCEEDING RELATING TO YOUR PROFESSIONAL CONDUCT, COMPETENCE, CAPACITY, OR TO ANY OTHER ASPECT OF YOUR MEDICAL PRACTICE, HAVE YOU EVER **VOLUNTARILY**:
    a. RESTRICTED YOUR MEDICAL LICENCE, CERTIFICATE OF REGISTRATION OR PERMIT TO PRACTISE?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. RESIGNED OR SURRENDERED YOUR MEDICAL LICENCE, CERTIFICATE OF REGISTRATION OR PERMIT TO PRACTISE?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. WITHDRAWN FROM YOUR PRACTICE OF MEDICINE?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    d. ENTERED A PLEA OF "NO CONTEST"?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

16. IN CONNECTION WITH ANY COMPLAINT RELATING TO YOUR PROFESSIONAL CONDUCT, COMPETENCE CAPACITY, OR TO ANY OTHER ASPECT OF YOUR MEDICAL PRACTICE, HAVE YOU EVER VOLUNTARILY:
    a. RESTRICTED YOUR MEDICAL LICENCE, CERTIFICATE OF REGISTRATION OR PERMIT TO PRACTISE?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. RESIGNED OR SURRENDERED YOUR MEDICAL LICENCE, CERTIFICATE OF REGISTRATION OR PERMIT TO PRACTISE?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. WITHDRAWN FROM YOUR PRACTICE OF MEDICINE?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    d. ENTERED A PLEA OF "NO CONTEST"?
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

17. HAVE YOU BEEN SUSPENDED, AS A RESULT OF PROFESSIONAL MISCONDUCT, OR ANY OTHER CAUSE, THAT IS RELEVANT TO YOUR SUITABILITY TO PRACTISE MEDICINE BY A REGULATORY AUTHORITY GOVERNING THE PRACTICE OF MEDICINE OR ANY OTHER HEALTH PROFESSIONAL IN CANADA OR ELSEWHERE?
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

18. ARE YOU RESUMING PRACTICE AFTER NOT BEING AUTHORIZED TO PRACTISE FOR TWO OR MORE CONSECUTIVE MONTHS IN ANOTHER JURISDICTION IN CANADA OR ELSEWHERE?
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

19. Have your privileges or legal authority to purchase, prescribe, possess, or dispense narcotic or other restricted drugs ever been:
    a. Restricted:
       ☐ No ☐ Yes Provide additional information: _____
    b. Reduced:
       ☐ No ☐ Yes Provide additional information: _____
    c. Withdrawn:
       ☐ No ☐ Yes Provide additional information: _____
    d. Voluntarily surrendered:
       ☐ No ☐ Yes Provide additional information: _____

LEGAL OR INSURANCE ACTIONS RELATED TO PROFESSIONAL CONDUCT

20. With respect to your practice of medicine or your professional activities, are you currently or have you ever been subject of any of the following actions:
    a. Legal action:
       ☐ No ☐ Yes Provide additional information: _____
    b. Insurance claim:
       ☐ No ☐ Yes Provide additional information: _____
    c. Other claim:
       ☐ No ☐ Yes Provide additional information: _____

21. With respect to a criminal offence, including offences under the Criminal Code of Canada, any narcotic or controlled substances legislation, the Income Tax Act, the Excise Tax Act, and any indictable offence in Canada, or similar offence in any jurisdiction other than Canada, have you ever:
    a. Been arrested:
       ☐ No ☐ Yes Provide additional information: _____
    b. Been convicted:
       ☐ No ☐ Yes Provide additional information: _____
    c. Been found guilty:
       ☐ No ☐ Yes Provide additional information: _____
    d. Pleaded guilty:
       ☐ No ☐ Yes Provide additional information: _____
    e. Been charged:
       ☐ No ☐ Yes Provide additional information: _____
    f. Pleaded no contest:
       ☐ No ☐ Yes Provide additional information: _____
    g. Filed any plea similar to "pleaded guilty" or "pleaded no contest":
       ☐ No ☐ Yes Provide additional information: _____
    h. Entered a diversion program:
       ☐ No ☐ Yes Provide additional information: _____
    i. Been pardoned:
       ☐ No ☐ Yes Provide additional information: _____

22. Have you ever been charged with or convicted or found guilty of, pleaded guilty to, pleaded no contest to, or filed any similar plea for any of the following offences in any jurisdiction:
    a. Illegal use of a professional title:
       ☐ No ☐ Yes Provide additional information: _____
    b. Illegal practice of a profession:
       ☐ No ☐ Yes Provide additional information: _____
    c. Have you ever had, in connection with your practice of medicine, a negligence claim made against you, been sued for negligence, had a negligence claim paid on your behalf, or paid such a claim yourself:
       ☐ No ☐ Yes Provide additional information: _____

23. Have you been convicted of an offence that is relevant to your suitability to practise medicine?
    ☐ No ☐ Yes Provide additional information: _____

24. Have you ever been sued in a civil action relating to fraud?
    ☐ No ☐ Yes Provide additional information: _____

25. Have you ever been named as a defendant in a civil action?
    ☐ No ☐ Yes (For each action include the particulars as shown below. Please submit on a separate sheet of paper if required.)

DATE OF ACTION (Y) _____

NAME OF PLAINTIFF: _____

NAME OF COURT: MBQB _____OTHER: _____
PLEASE INCLUDE PROVINCE, STATE OR COUNTRY

COURT FILE NUMBER: _____

NATURE OF ALLEGATIONS:

STATUS OF ACTION:
(I) STILL PENDING ____

(II) RESOLVED BY SETTLEMENT ____ DATE (Y): _____ WITH PAYMENT TO PLAINTIFF: YES ___ NO ___
(A SETTLEMENT MEANS AN AGREEMENT TO RESOLVE A LAWSUIT INVOLVING A PATIENT AT ANY TIME DURING THE PROCEEDING, WHICH INCLUDED ANY PAYMENT OF MONEY IN RELATION TO YOUR MEDICAL PRACTICE AND/OR ANY ADMISSION OF LIABILITY IN RELATION TO YOUR MEDICAL CARE.)

(III) FINDING (JUDGMENT) ____ DATE (D/M/Y) _____
(A FINDING MEANS ANY JUDGMENT OR DECISION MADE AGAINST YOU BY A COURT IN RELATION TO A CIVIL ACTION AND INCLUDES ANY FINDINGS IN WHICH YOU WERE FOUND BY THE COURT TO BE LIABLE FOR THE ACTIONS OF OTHERS, E.G. EMPLOYEES, MEDICAL STUDENTS, IN AN ACTION INVOLVING A PATIENT.)

(IV) ACTION DISMISSED BY THE COURT, DISCONTINUED BY THE PLAINTIFF, OR WITHDRAWN BY THE PLAINTIFF WITHOUT ANY PAYMENT TO THE PLAINTIFF AND/OR ANY ADMISSION OF LIABILITY IN RELATION TO YOUR MEDICAL CARE. – DATE (Y) ____

26. HAVE YOU EVER BEEN, OR ARE YOU NOW, THE SUBJECT OF ANY RESTRICTION, TERMINATION OR SUSPENSION OF YOUR ABILITY TO WORK IN ANY PROFESSION OR OCCUPATION, OR IN ANY SETTING?
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

27. DO YOU HAVE ANY PENDING CRIMINAL CHARGES, WHETHER IN CANADA OR ELSEWHERE?
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION AS FOLLOWS:

DATE OF CHARGE (DD/MM/YYYY) _____

NAME OF COURT: _____

COURT FILE NUMBER: _____

NATURE OF CHARGES, OR SUBMIT A COPY OF THE CHARGES:

28. DO YOU HAVE **PENDING** AGAINST YOU ANY OTHER TYPE OF CHARGES OR OTHER PROCEEDINGS FOR STATUTORY OFFENCES RELEVANT TO YOUR PRACTICE OF MEDICINE OR ANY OTHER PROFESSION (E.G. CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT, CHARES UNDER THE FOOD AND DRUGS ACT, CHARGES OF FRAUD OR PROCEEDINGS FOR A RESTRAINING ORDER)?
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION AS FOLLOWS:

DATE OF CHARGE/PROCEEDING (DD/MM/YYYY) _____

NAME OF COURT: _____

COURT FILE NUMBER: _____

NATURE OF CHARGES, OR SUBMIT A COPY OF THE CHARGES OR NOTICE OF THE OTHER PROCEEDING:

29. HAS A COURT EVER ISSUED A RESTRAINING ORDER AGAINST YOU?
☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION AS FOLLOWS:

DATE OF ORDER (DD/MM/YYYY) _____

NAME OF COURT: _____

COURT FILE NUMBER: _____

NATURE OF THE ORDER, OR SUBMIT A COPY OF THE ORDER:

HOSPITAL, HEALTH FACILITY, OR HEALTH AUTHORITY ACTIONS

30. HAVE YOU EVER BEEN DENIED ANY OF THE FOLLOWING IN A HOSPITAL OR OTHER HEALTH FACILITY:
    a. PRIVILEGES:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. REAPPOINTMENT OR REINSTATEMENT OF PRIVILEGES:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. APPOINTMENT TO MEDICAL STAFF:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    d. REAPPOINTMENT TO MEDICAL STAFF:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

31. HAS A HOSPITAL OR OTHER HEALTH FACILITY EVER CHANGED YOUR PRIVILEGES IN ANY OF THE FOLLOWING WAYS:
    a. SUSPENDED:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. LIMITED-FOR-CAUSE:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. RESTRICTED OR REDUCED:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    d. REVOKED OR REMOVED:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    e. CANCELLED:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    f. WITHDRAWN:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    g. NOT RENEWED:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

32. HAVE YOU EVER VOLUNTARILY GIVEN UP, RELINQUISHED, CHANGED, OR AGREED NOT TO EXERCISE YOUR PRIVILEGES, OR RESIGNED FROM A HEALTH AUTHORITY, HOSPITAL OR OTHER HEALTH FACILITY, AT ANY OF THE FOLLOWING TIMES:
    a. WHILE FACING ALLEGATIONS OF PROFESSIONAL MISCONDUCT, MALPRACTICE, INCOMPETENCE OR INCAPACITY:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. DURING, SUBSEQUENT TO, OR IN LIEU 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:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. WHILE DISCIPLINARY ACTION WAS PENDING:
    ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

33. Within the last three years, have you been the subject of any review of your conduct, competence, or capacity or fitness to practise, whether arising from a complaint or otherwise, by an entity other than a body with authority to regulate the practice of medicine or any other profession?

☐ No ☐ Yes Provide additional information: _____

CONDUCT DURING UNDERGRADUATE MEDICAL EDUCATION

34. During your undergraduate medical education were you ever the subject of any of the following actions conducted through a hospital or other health facility, in any jurisdiction:
    a. Complaint:
       ☐ No ☐ Yes Provide additional information: _____
    b. Inquiry or investigation:
       ☐ No ☐ Yes Provide additional information: _____
    c. Restriction of the scope of your medical practice:
       ☐ No ☐ Yes Provide additional information: _____
    d. Disciplinary action:
       ☐ No ☐ Yes Provide additional information: _____
    e. Dismissal:
       ☐ No ☐ Yes Provide additional information: _____

35. During your undergraduate medical education, have you ever:
    a. Withdrawn:
       ☐ No ☐ Yes Provide additional information: _____
    b. Been expelled:
       ☐ No ☐ Yes Provide additional information: _____
    c. Been suspended:
       ☐ No ☐ Yes Provide additional information: _____
    d. Been put on probation:
       ☐ No ☐ Yes Provide additional information: _____
    e. Required remediation by a medical school or educational institution for any reason:
       ☐ No ☐ Yes Provide additional information: _____
    f. Resigned in lieu of an inquiry:
       ☐ No ☐ Yes Provide additional information: _____

36. Were you ever the subject of any type of investigation, inquiry or proceeding by a medical school or educational institution for any of the following reasons:
    a. Academic misconduct or misconduct of any type:
       ☐ No ☐ Yes Provide additional information: _____
    b. Issues related to your conduct, competence, character, capacity or fitness to practise:
       ☐ No ☐ Yes Provide additional information: _____
    c. Were you ever investigated or sanctioned by any academic or research body for misconduct of any type or for any violation of academic policy?
       ☐ No ☐ Yes Provide additional information: _____

37. During your undergraduate medical education, did you ever:
    a. Take a leave of absence from or otherwise interrupt your undergraduate medical education for three (3) months or longer?
       ☐ No ☐ Yes Provide additional information: _____
    b. Transfer from one undergraduate medical educational program to another?
       ☐ No ☐ Yes Provide additional information: _____

CONDUCT DURING POSTGRADUATE MEDICAL TRAINING

38. During any of your internship, residency, fellowship, postgraduate training, educational or other institutional training, have you ever been:
    a. Investigated:
       ☐ No ☐ Yes Provide additional information: _____
    b. Suspended:
       ☐ No ☐ Yes Provide additional information: _____
    c. Removed, dismissed, expelled, or prematurely terminated from the program:
       ☐ No ☐ Yes Provide additional information: _____

d. PUT ON PROBATION:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
e. PUT ON REMEDIATION:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
f. SUBJECT TO REVOCATION OF YOUR TRAINING APPOINTMENT:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
g. ADVISED TO WITHDRAW:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
h. OTHERWISE DISCIPLINED:
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

39. HAVE YOU EVER WITHDRAWN OR RESIGNED FROM ANY OF YOUR POSTGRADUATE MEDICAL TRAINING?
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

40. AT ANY TIME DURING AN INTERNSHIP, RESIDENCY, FELLOWSHIP, POSTGRADUATE TRAINING, EDUCATIONAL OR OTHER INSTITUTIONAL TRAINING, HAVE YOU EVER:
    a. TAKEN A LEAVE OF ABSENCE FROM OR OTHERWISE INTERRUPTED YOUR POSTGRADUATE MEDICAL TRAINING PROGRAM FOR THREE (3) MONTHS OR LONGER:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    b. TRANSFERRED FROM ONE POSTGRADUATE MEDICAL TRAINING PROGRAM TO ANOTHER WITHOUT HAVING COMPLETED THE FIRST PROGRAM:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____
    c. BEGUN A MEDICAL TRAINING PROGRAM OF ANY DESCRIPTION THAT YOU DID NOT COMPLETE:
       ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

ABSENCES FROM PRACTICE

41. HAVE YOU EVER CEASED, INTERRUPTED, OR BEEN AWAY FROM PRACTICE FOR THREE (3) MONTHS OR LONGER?
   ☐ NO ☐ YES PROVIDE THE FOLLOWING INFORMATION FOR EACH ABSENCE (USE SEPARATE SHEET IF NECESSARY):

FROM DATE:	
TO DATE:	
REASON FOR NOT PRACTISING:	

FITNESS TO PRACTISE

HARM IS DEFINED AS ANY DETRIMENT TO OR NEGATIVE IMPACT ON A PERSON. RISKS OF HARM IS DEFINED AS INCLUDING THE RISK OF UNSAFE OR INCOMPETENT CARE PROVIDED TO PATIENTS AND NEGATIVE IMPACTS IN OTHER AREAS OF WORK, INCLUDING, BUT NOT LIMITED TO, RESEARCH, EDUCATION AND ADMINISTRATION.

42. DO YOU HAVE, OR HAS ANYONE EVER ADVISED YOU THAT YOU HAVE, A PHYSICAL, COGNITIVE, MENTAL AND/OR EMOTIONAL CONDITION WHICH IN ANY WAY MAY REASONABLY BE EXPECTED TO POSE A RISK OF HARM TO PATIENTS OR NEGATIVELY IMPACT YOUR WORK AS A PHYSICIAN?
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

43. HAVE YOU EVER HAD, OR HAVE YOU EVER BEEN ADVISED THAT YOU HAD, A PHYSICAL, COGNITIVE, MENTAL AND/OR EMOTIONAL CONDITION WHICH IN ANY WAY MAY, SHOULD IT REOCCUR, REASONABLY BE EXPECTED TO POSE A RISK OF HARM TO PATIENT OR NEGATIVELY IMPACT YOUR WORK AS A PHYSICIAN?
   ☐ NO ☐ YES PROVIDE ADDITIONAL INFORMATION: _____

44. DOES YOUR CURRENT SCOPE OF PRACTICE INCLUDE EXPOSURE PRONE PROCEDURES (EPP) AS DEFINED BY SCHEDULE J OF THE STANDARDS OF PRACTICE OF MEDICINE (ATTACHED)?
   EXPOSURE PRONE PROCEDURES (EPP) – INTERVENTIONS WHERE THERE IS A RISK THAT INJURY TO THE MEMBER MAY RESULT IN THE EXPOSURE OF THE PATIENT'S OPEN TISSUES TO BLOOD AND BODY FLUIDS OF THE MEMBER (BLEEDBACK). THESE INCLUDE PROCEDURES WHERE THE MEMBER'S GLOVED HAND MAY BE IN CONTACT WITH SHARP INSTRUMENTS, NEEDLE TIPS OR SHARP TISSUES (SPICULES OF BONE OR TEETH) INSIDE A PATIENT'S OPEN BODY CAVITY, WOUND OR CONFINED ANATOMICAL SPACE WHERE THE HANDS OR FINGER TIPS MAY NOT BE COMPLETELY VISIBLE AT TIMES.
   ☐ NO ☐ YES **IF YES, ANSWER QUESTION 45**

45. Have you ever been advised that you have any of the following bloodborne pathogens:
    a. Human Immunodeficiency Virus (HIV)?
       ☐ No ☐ Yes
    b. Hepatitis B Virus (HBV)?
       ☐ No ☐ Yes
    c. Hepatitis C Virus (HCV)?
       ☐ No ☐ Yes

CHILD AND ADULT ABUSE REGISTRY

46. Have you ever been placed on a national, state or provincial child abuse registry any where in the world, including Manitoba's Child Abuse Registry?
    ☐ No ☐ Yes If yes,

    Date of the Entry _____

    Name of National, State or Provincial Abuse Registry and Location

    _____

    Please Provide Details

47. Have you ever been placed on a national, state or provincial adult abuse registry any where in the world, including Manitoba's Adult Abuse Registry?
    ☐ No ☐ Yes If yes,

    Date of the Entry _____

    Name of National, State or Provincial Abuse Registry and Location

    _____

    Please Provide Details

LIABILITY COVERAGE

48. Do you carry or will immediately arrange and continue liability coverage/protection appropriate to your practice?
    ☐ No ☐ Yes Provide additional information: _____

49. If applicable, provide a description of the continuing professional development activities that you were required to complete as a condition of being authorized to practise medicine in Canada in the past 3 years immediately preceding this application and indicate how you met those requirements.

DECLARATION

I hereby declare that the information provided on this form is complete, accurate and factually correct.

I hereby consent to allow the College of Physicians and Surgeons of Manitoba (CPSM) to:

A. make such inquiries about me as it considers necessary in connection with my application for medical registration and licensure.
B. investigate and obtain such other information as the Registrar may require in connection with this application.
C. allow CPSM to disclose information about me, including, for example, copies of this form and the results of the Medical Council of Canada examinations, to other regulatory authorities, federations of regulatory authorities, health authorities, hospitals and other institutions to which I apply for appointment, privileges or training. This does not include letters of reference which are provided in confidence.

I understand that I am deemed not to have satisfied the requirements and qualifications for registration/licensure if, in connection with this application or a past application, I have made a false or misleading representation, either because of what was stated or left unstated or given any other false or fraudulent representation or declaration either oral or written, and that on that basis, my registration and licensure may be revoked.

I shall inform the Registrar immediately in writing of any change of my professional and mailing address and telephone number and email address.

I hereby declare the following:

1. I am the person making application for registration/licensure to practise medicine in the Province of Manitoba.
2. The photograph I am submitting to CPSM is an unaltered photograph of me taken within the last six months prior to making this application.
3. This application was completed by me.
4. The answers I have given to the questions in the application to which this declaration is attached are true, complete and given without intent to mislead.
5. I understand that the result letter issued will be based on the information provided in this application. 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 virtue of the Canada Evidence Act.

If my application is successful, and I am granted registration, I hereby pledge my adherence to the by-laws, standards of practice, general principles and ethics of the practice of medicine as established by Council of CPSM.

I acknowledge that I have read CPSM Standards of Practice of Medicine – Schedule J – Bloodborne Pathogens (link below) and I understand my obligations and accept the terms and conditions above.

SCHEDULE J OF THE STANDARDS OF PRACTICE OF MEDICINE (PAGE 84)

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Date Signature

This application is valid for six months only from date of receipt in the CPSM offices.
An update application will be required if your registration is not issued within that period.