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**CLINICAL ASSISTANT APPLICATION
(VIA WEB)**

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.

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.

(1) Submit this application and the \$275.00 documentation fee. **FEES ARE NON-REFUNDABLE.**

(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: <i>(last, first, middle)</i>	
OTHER NAMES YOU HAVE BEEN KNOWN BY:	DATE OF BIRTH: <i>(month, day, year)</i>
HOME ADDRESS: <i>(Street, City, State/Province)</i>	Use as mailing address?
E-MAIL ADDRESS	
PRACTICE ADDRESS:	Use as mailing address?

1. IN THE FORMAT SHOWN BELOW ATTACH A 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	NO

2. CREDENTIALS

MEDICAL DEGREE Date

University
 (See form Certification by Medical School/University/College)

MEDICAL IDENTIFICATION NUMBER FOR CANADA (MINC): CAMD - _____ - _____ (If you do not have a MINC number, CPSM will provide the following information to the Medical Council of Canada to issue a number: name, DOB, sex, family name, given name, degree year, degree institution.)

REGULATED HEALTH PROFESSION IN MANITOBA

..... Date

University/College
 (See form Certification by Medical School/University/College)

2. Credentials continued

EMERGENCY MEDICAL ATTENDANT – LEVEL III
 Certification Date

PHYSICIAN ASSISTANT OR CLINICAL ASSISTANT TRAINING PROGRAM

PHYSICIAN ASSISTANT TRAINING PROGRAM: (Name of Program, City, State/Prov)		DIPLOMA DATE:
IF APPLICABLE, NCCPA CERT. DATE :	NCCPA NUMBER:	OTHER CERTIFICATION

3. 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)
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4. 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*.

1. ANY OF THE FOLLOWING ACTIONS BY A BODY WITH AUTHORITY TO REGULATE A PROFESSION:

(a) HAVE YOU EVER BEEN THE SUBJECT OF A REVIEW OF YOUR CONDUCT, COMPETENCE, OR CAPACITY OR FITNESS TO PRACTISE, WHETHER ARISING FROM A COMPLAINT OR OTHERWISE?

No Yes Give Particulars

(b) ARE YOU CURRENTLY THE SUBJECT OF AN INVESTIGATION OR OTHER PROCEEDING IN RELATION TO YOUR CONDUCT, COMPETENCE, OR CAPACITY OR FITNESS TO PRACTISE?

No Yes Give Particulars

(c) HAVE YOU EVER BEEN THE SUBJECT OF A FINDING OF PROFESSIONAL MISCONDUCT, CONDUCT UNBECOMING, INCOMPETENCE, INCOMPETENCE, OR AN INCAPACITY OR LACK OF FITNESS TO PRACTISE?

No Yes Give Particulars

(d) HAVE YOU EVER BEEN DENIED AN APPLICATION FOR LICENSURE, REGISTRATION, PERMIT OR ANY OTHER AUTHORIZATION TO PRACTISE?

No Yes Give Particulars

(e) HAVE YOU EVER BEEN THE SUBJECT OF A SUSPENSION OF, RESTRICTION ON, OR REVOCATION OF LICENSURE, REGISTRATION, PERMIT OR ANY OTHER AUTHORITY TO PRACTISE?

No Yes Give Particulars

2. 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 A PROFESSION?

No Yes Give Particulars

3. 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 Give Particulars

4. HAVE YOU EVER SUFFERED FROM, OR BEEN TREATED FOR, OR ARE YOU CURRENTLY BEING TREATED FOR ANY PHYSICAL OR MENTAL CONDITION, DISORDER, OR ADDICTION TO ALCOHOL OR DRUGS THAT MAY COMPROMISE YOUR ABILITY TO PRACTISE MEDICINE SAFELY?

No Yes Give Particulars

5. HAVE YOU EVER ENTERED A GUILTY PLEA TO, OR BEEN CONVICTED OF A CRIMINAL OFFENCE OR AN OFFENCE UNDER ANY NARCOTIC OR CONTROLLED SUBSTANCES LEGISLATION?

No Yes Give Particulars

6. HAVE YOU EVER FAILED A QUALIFYING EXAMINATION FOR A STATE, PROVINCIAL OR NATIONAL EXAMINATION FOR A LICENCE TO PRACTISE A HEALTH CARE PROFESSION?

No Yes Give Particulars

7. HAVE YOU EVER ENGAGED IN THE UNLICENSED PRACTICE OF ANY HEALTH CARE PROFESSION IN ANY JURISDICTION FOR WHICH THE PRACTICE OF THE HEALTH CARE PROFESSIONAL REQUIRED A LICENCE?

No Yes Give Particulars

8. HAVE YOU INTERRUPTED THE PRACTICE OF YOUR HEALTH CARE PROFESSIONAL FOR ONE YEAR OR MORE, OR CEASED THE PRACTICE OF YOUR SPECIALTY?

No Yes Give Particulars

9. HAVE YOU EVER BEEN RESTRICTED, SUSPENDED, TERMINATED, REQUESTED TO VOLUNTARILY RESIGN, PLACED ON PROBATION OR BEEN SUBJECT TO FORMAL DISCIPLINARY ACTION WITH RESPECT TO YOUR TRAINING AND/OR PRACTICE OF A HEALTH CARE PROFESSION?

No Yes Give Particulars

WARNING: THE MANITOBA MEDICAL ACT STATES THAT WHERE ANY PERSON PROCURES HIS OR HER REGISTRATION, OR CAUSES IT TO BE PROCURED, BY MEANS OF ANY FALSE OR FRAUDULENT REPRESENTATION, EITHER ORALLY OR IN WRITING, THAT PERSON'S REGISTRATION WILL BE CANCELLED.

WHERE IN MANITOBA DO YOU INTEND TO PRACTISE:

Location/Clinic/Office Address
(full mailing address)

Expected Start Date

DECLARATION

- 1. The information contained in this application is true to the best of my knowledge, information and belief.
- 2. I authorize the College of Physicians and Surgeons of Manitoba (the College), to make inquiries, written or verbal, of any licensing authority which has licensed or refused to license me, and/or of any of my previous employers, current employers, associates, partners, university(s) where I have trained or held an appointment either as a member of the faculty or research, or references, and I authorize any such authority or person to release to the College verbally and/or in writing as the College may request, such information as the College in its sole discretion may require relating to my application for registration.
- 3. I will keep the Registrar informed immediately of any change of office address while practising in Manitoba.

.....
Date

.....
Signature

REFERENCES (Please Print)

List three persons (none of whom is related to you) with recent professional/educational knowledge of you. Include full mailing addresses. Incomplete addresses will delay processing.

	Name	Address
1.
2.
3.

TO AVOID DELAYS IN PROCESSING YOUR APPLICATION HAVE YOU INCLUDED:

1. Originals or certified copies (not photocopies) of all supporting documents
2. \$275 documentation fee (non-refundable)

THE COLLEGE RESERVES THE RIGHT TO REQUEST ADDITIONAL DOCUMENTATION AS MAY BE REQUIRED AFTER A REVIEW OF THE APPLICATION