



MANITOBA MEDICAL REGISTER APPLICATION
CONDITIONAL REGISTRATION
(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.

Name.....
Print in full, underline surname

If legal change of name, please indicate.....

Present Mailing Address
.....
.....

E-Mail Address

Preferred method of communication: mailing address e-mail address

Date of Birth M: D: Y:

MEDICAL DEGREE

Degree Date.....

University

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.)

A. HAVE YOU EVER WRITTEN/BEEEN ASSESSED BY/APPLIED TO WRITE/OR BE ASSESSED BY: (YOU MUST ANSWER 1 THROUGH 7) ENCLOSE EVIDENCE (ORIGINAL OR CERTIFIED COPY)

Table with 4 columns: Question, No, Yes, P/F, Date(s) P/F. Rows include Medical Council of Canada Evaluating Examination, Medical Council of Canada Qualifying Examination (Parts I, II, and prior to 1992), College of Family Physicians of Canada (Certification and Eligible for Examination), Royal College of Physicians and Surgeons of Canada Specialty, American Board Certification Specialty, FLEX/USMLE, and Canadian licensing authority Specialty or General Practice.

LIST ALL OTHER JURISDICTIONS IN WHICH YOU HOLD/HELD REGISTRATION
(USE SEPARATE SHEET IF NECESSARY)

Date of Registration

Current Y/N

.....
.....
.....
.....

B. Postgraduate clinical training. Enclose evidence of postgraduate clinical training. Training completed outside a CACMS/LCME approved residency training program must meet the requirements of Appendix A.

C. CURRICULUM VITAE (Your CV must be in the following format for dates: dd/mm/yyyy)

1. Enclose a detailed curriculum vitae outlining all activities from date of graduation to the present (include all professional experience, work locations and additional training). If there are any periods of time during which you were neither working as a physician nor in a training program, the CV must provide an explanation for such gaps.

2. Type of practice:

(a) **If you are currently in general practice, enclose a description of your current practice:** Are there any of the primary care (general practice) fields of medicine (e.g. obstetrics/deliveries, paediatrics, general medicine, general surgery, anaesthesia) in which you have not practised during the past three years?

No Yes (If yes, please provide particulars on a separate sheet.)

(b) **For Specialty Practice:**

(i) Do you currently limit your practice to a specialty area?

No Yes (If yes, Name of Specialty Please provide full particulars on a separate sheet.)

(ii) Have you ever practised in a specialty area?

No Yes (If yes, Name of Specialty Please provide full particulars on a separate sheet.)

3. Currently Practising? No Yes

If no, indicate date last practised..... (enclose a description of your previous practice)

D. 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, 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

WARNINGS: THE MANITOBA MEDICAL ACT STATES THAT WHERE ANY PERSON PROCURES HIS 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.

REFERENCES. See Last Page.

WHERE IN MANITOBA DO YOU INTEND TO PRACTISE:

Location/Clinic/Office Address
(full mailing address)

Expected Start Date

What Type of Practice: General Practice OR Specialty (indicate specialty)

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 authorize the Medical Council of Canada (Medical Council) to release to the College the results of the Qualifying Examinations (Part I and Part II).
4. I will keep the Registrar informed immediately of any change of office address while practising in Manitoba.

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Date Signature

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

TO AVOID DELAYS IN PROCESSING YOUR APPLICATION HAVE YOU?

1. Included documents as per the enclosed checklist.
2. Included \$275 documentation fee (non-refundable).
3. Answered **all** the questions on the application form. Failure to complete all the questions, including Item A 1 through 7 on page 1, will result in the application being returned to you with the request that the missing items be completed.

REFERENCES

List three persons with recent professional/educational knowledge of you, none of whom may be related to you and one of whom must be:

- (a) for physicians who have recently completed postgraduate clinical training, your supervisor responsible for training.
- (b) a physician in a supervisory position in a hospital where you have practised most recently
- (c) a physician colleague with whom you have practised most recently.

Include full mailing addresses and a contact telephone number or e-mail address. Incomplete addresses will delay processing. Please Print Clearly.

	Name	Address/E-Mail/Phone Number
1.
2.
3.

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