



# Application for Medical Practice Northwest Territories

<p style="text-align: center;"><b>Provide a recent passport-type photograph of yourself (taken within the last six months)</b> <b>Application considered incomplete without photograph.</b></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 33%;">Last Name</td> <td style="border-bottom: 1px solid black; width: 33%;">First Name</td> <td style="border-bottom: 1px solid black; width: 33%;">Middle Name</td> </tr> <tr> <td style="border-bottom: 1px solid black;">(Apt #)</td> <td colspan="2" style="border-bottom: 1px solid black;">(Street or postal box number)</td> </tr> <tr> <td style="border-bottom: 1px solid black;">(City, Town, Village)</td> <td style="border-bottom: 1px solid black;">(Province/State)</td> <td style="border-bottom: 1px solid black;">(Postal/Zip Code)</td> </tr> <tr> <td colspan="2">Phone: _____</td> <td>Fax: _____</td> </tr> <tr> <td colspan="3">E-Mail _____</td> </tr> </table> <p style="font-size: small;">Note: License and other correspondence will be sent to this address unless otherwise advised. Advise Registrar immediately of any change of address.</p>	Last Name	First Name	Middle Name	(Apt #)	(Street or postal box number)		(City, Town, Village)	(Province/State)	(Postal/Zip Code)	Phone: _____		Fax: _____	E-Mail _____		
Last Name	First Name	Middle Name														
(Apt #)	(Street or postal box number)															
(City, Town, Village)	(Province/State)	(Postal/Zip Code)														
Phone: _____		Fax: _____														
E-Mail _____																
<p><b>Date of Birth: (dd/mm/yy)</b> _____</p> <p><b>Canadian Citizen:</b></p> <p><input type="checkbox"/> Yes (attach copy of birth certificate or proof of citizenship)</p> <p><input type="checkbox"/> No (attach copy of work auth. or immigration document)</p>	<p><b>Language Fluency:</b></p> <p><input type="checkbox"/> English <input type="checkbox"/> French</p> <p><input type="checkbox"/> Other, specify: _____</p>															
<p><b>Location and Dates of Intended Practice in the Northwest Territories:</b></p> <p>Physician/Medical Clinic(s) _____</p> <p>Location _____</p> <p>Contact Name/Telephone #: _____</p> <p>Type of License/Permit Requested*: _____ Anticipated Dates of Practice: _____</p> <p>(*See List of Requirements for License or Permit Types)</p>																
<p><b>Medical Degree (attach certified copy of medical degree, translated if not in English)</b></p> <p>_____/_____/_____ (Grad Month / Year)      Name of Medical School - Province/State/Country</p>																
<p><b>Family Practice or Specialty Training (attach copies of certification)</b></p> <p>_____/_____/_____ TO ____/____/_____ DD MM YY)      DD MM YY      Location (Province/State/Country) (Specialty)</p> <p>_____/_____/_____ TO ____/____/_____ (DD MM YY)      DD MM YY      Location (Province/State/Country) (Specialty)</p>																
<p><b>Licensure: List jurisdiction and dates of all current and previous licensure:</b></p> <p>_____</p>																
<p><b>Indicate which of the following you have (provide copies of all certificates):</b></p> <p><input type="checkbox"/> LMCC      <input type="checkbox"/> CCFP      <input type="checkbox"/> RCPSC      <input type="checkbox"/> CMQ , <input type="checkbox"/> Other _____</p>																
<p><b>References:</b> (Provide the names and address of three (3) character references, at least two (2) must be physicians with whom you have worked in the past three (3) years. Supply these referees with a copy of the NWT Medical Reference Form).</p> <p>1) _____      2) _____      3) _____</p> <p>_____</p> <p>_____</p> <p>_____</p>																

<b>Personal Information</b> (Check the appropriate box. <b>If answer is yes</b> to any question, <b>provide full explanation/details</b> on a separate sheet of paper.)	Yes	No
1. Have you ever been or are you currently being treated for any illness or disability that could affect your practice of medicine?		
2. Have you ever been refused a medical license?		
3. Has your medical license, registration or right to practice in any jurisdiction been revoked, suspended or restricted in any way?		
4. Have you ever been or are you currently being treated for any addictions such as alcohol abuse, drug abuse, gambling etc.?		
5. Have you ever had your hospital privileges revoked, suspended or restricted?		
6. Have you ever had an internship, residency, hospital or other institutional appointment prematurely terminated or interrupted?		
7. Have you ever been charged or convicted of a criminal or similar offence?		
8. Have you ever been placed on a list restricting purchase or prescribing narcotic drugs?		
9. Are you presently the subject of an allegation, complaint or investigation by any medical licensing authority?		
10. Are you aware of any inquiry likely to be made by any authority, licensing or otherwise, with respect to your conduct, personal behavior or competence?		
11. Have you ever had the right to bill, restricted or removed by a health care paying agency?		
12. Have you previously applied for, or have been issued, a license or certificate of registration in the Northwest Territories. If yes, when? <span style="float: right;">License # (if known)</span>		

**Declaration**

**I authorize** the Medical Registration Committee to investigate and obtain from any person or persons, such information as may be required in relation to this application. **I certify** that the statements made by me in this application are true and complete. **I am aware** that misrepresentation or falsification of information may result in rejection of my application or withdrawal of registration and may result in such information being shared with other Licensing Authorities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Forward completed application, with required attachments, to:  Registrar, Health Professional Licensing Department of Health & Social Services Government of the Northwest Territories 8 <sup>th</sup> Floor Centre Square Tower (5022-49 ST) P.O. Box 1320, YELLOWKNIFE, NT X1A 2L9 Telephone: (867) 920-8058	If paying by Visa or Mastercard, complete the following. ( <b>See list of requirements for license type and fee amounts.</b> ) Name on Card: _____ Card Number: _____ Card Expiry Date: _____ Amount: _____  Authorized Signature: _____
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This personal information is being collected under the authority of the *Medical Profession Act* of the NWT and will be used to process Application to Practice Medicine. The privacy provisions of the *Access to Information and Protection of Privacy Act* of the NWT protect information collected. If you have any questions about the collection, contact the Registrar's Office at the above address.