



Requirements for application for Medical Licence in the Northwest Territories:

1. Completed application with photograph attached (incomplete applications will not be processed).
 2. Specified location of work (please specify name of clinic or hospital) and planned start date.
 3. **Certified** copy of medical degree (certified by a Notary Public or Commissioner for Oaths); **or** a transcript of records, mailed directly to the Registrar from the Medical School. **If not in English or in French the applicant must provide a translation.**
- Note: If medical training was not in English, proof of fluency in speaking and understanding the English language will be required (submit results of Test of English as a Foreign Language (TOEFL)).
4. Photocopy of Licentiate of the Medical Council of Canada (LMCC).
 5.
 - a) For family physicians: Photocopy of College of Family Physicians of Canada certificate; **or** proof of completion of **two years** post-graduate internship training in Family Medicine, with rotations in medicine, surgery, paediatrics, obstetrics, gynaecology and psychiatry. **Note:** physicians fully licensed in Canada before November 1999 with one year of post-graduate training will be considered as having completed the two year residency requirement as outlined above. Family physicians must provide proof of being licensed or being eligible to be licensed in a province – this is normally provided on the provincial Certificate of Standing.
 - b) For specialists: Photocopy of certification by Royal College of Physicians and Surgeons of Canada **or** the Professional Corporation of Physicians of Quebec. Specialists must provide proof of being licensed or eligible to be licensed in their speciality in a province. Proof of this is to be provided on the provincial Certificate of Standing.
 6. Letters (Certificates) of Standing from all licensing authorities that applicant is/has been licensed **sent directly to Registrar from the licensing authority.** **Note:** The Registrar cannot provide anyone with copies. If applying for hospital/health board privileges, have a copy sent directly to them.
 7. Up-to-date and detailed curriculum vitae/resume.
 8. Three references, **from individuals who can comment on applicant's work, sent directly to the Registrar.** Reference forms are supplied with the application package. Referees must have worked with the applicant within the past three years. **Note:** The Registrar cannot provide anyone with copies. If applying for hospital/health board privileges, have separate references sent directly to them.
 9. Photocopy of proof of citizenship i.e. Canadian birth certificate, or valid immigration document.
 10. Cheque, Money Order, or Visa Authorization payable to Government of the N.W.T., for one of:
 - **registration & annual licence** - \$300.00 (\$100 initial registration fee plus \$200 due annually) - licence expires March 31st following date of issue, renewable upon payment of fee; **or**
 - **registration and limited permit** - \$150.00 (\$100 initial registration fee plus \$50.00 for each subsequent permit) valid for 3 months from the date of issue (not renewable, may be applied for twice in a fiscal year); **or**
 - **research permit** - valid for 12 months maximum - \$100.00 (licence can be renewed upon application.

NOTE: Except for #6 and #8 above, all documents should be sent in one package to:
Registrar, Professional Licensing, Health & Social Services, Government of the Northwest Territories
8th Floor Centre Square Tower, 5022-49 Street, Box 1320, Yellowknife NT X1A 2L9

**** Failure to forward documents as stated above will delay and possibly prevent licensing**
****GENERALLY, PLEASE ALLOW 6 WEEKS FOR PROCESSING OF APPLICATIONS****

Application Package requirements posted on the Professional Licensing website supersedes any prior application packages in circulation



Application for Medical Practice Northwest Territories

<p style="text-align: center;">Provide a recent passport-type photograph of yourself (taken within the last six months) Application considered incomplete without photograph.</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">Last Name</td> <td style="width: 33%; border-bottom: 1px solid black;">First Name</td> <td style="width: 33%; border-bottom: 1px solid black;">Middle Name</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black;">(Mailing Address)</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="3" style="border-bottom: 1px solid black;">(Office or Residential Street Address if above is a PO Box)</td> </tr> <tr> <td colspan="3">Phone: _____ 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 the mailing address unless otherwise advised. Advise Registrar immediately of any change of address.</p>	Last Name	First Name	Middle Name	(Mailing Address)			(City, Town, Village)	(Province/State)	(Postal/Zip Code)	(Office or Residential Street Address if above is a PO Box)			Phone: _____ Fax: _____			E-Mail _____		
Last Name	First Name	Middle Name																	
(Mailing Address)																			
(City, Town, Village)	(Province/State)	(Postal/Zip Code)																	
(Office or Residential Street Address if above is a PO Box)																			
Phone: _____ Fax: _____																			
E-Mail _____																			
<p>Date of Birth: (mm/dd/yy) _____</p> <p>Canadian Citizen:</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>Language Fluency:</p> <p><input type="checkbox"/> English <input type="checkbox"/> French</p> <p><input type="checkbox"/> Other, specify: _____</p>																		
<p>Location and Dates of Intended Practice in the Northwest Territories:</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>Medical Degree (attach certified copy of medical degree, translated if not in English)</p> <p>_____/_____/_____</p> <p>(Grad Month / Year) Name of Medical School - Province/State/Country</p>																			
<p>Family Practice or Specialty Training (attach copies of certification)</p> <p>_____/_____/_____ TO _____/_____/_____ _____</p> <p>(DD MM YY) (DD MM YY) Location (Province/State/Country) (Specialty)</p> <p>_____/_____/_____ TO _____/_____/_____ _____</p> <p>(DD MM YY) (DD MM YY) Location (Province/State/Country) (Specialty)</p>																			
<p>Licensure: List jurisdiction and dates of all current and previous licensure:</p> <p>_____</p> <p>_____</p>																			
<p>Indicate which of the following you have (provide copies of all certificates):</p> <p><input type="checkbox"/> LMCC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> CMQ <input type="checkbox"/> Other _____</p>																			
<p>References: (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>																			

Personal Information (Check the appropriate box. If answer is yes to any question, provide full explanation/details 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? License # (if known)		

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 th 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. (See list of requirements for license type and fee amounts.) 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.

Please copy this form if additional copies are required.

**REFERENCE FORM FOR PHYSICIANS APPLYING FOR
MEDICAL LICENSURE IN THE NORTHWEST TERRITORIES -**

PLEASE MAIL COMPLETED FORM DIRECTLY TO:

**Office of the Registrar, Professional Licensing, Department of Health & Social Services -
Government of the NWT, Box 1320 (Centre Square Tower - 8th Floor) - Yellowknife, NWT X1A 2L9
Telephone: (867)920-8058 Facsimile: (867) 873-0484**

NAME OF APPLICANT (PLEASE PRINT):

I authorize the referee to disclose to the Medical Registration Committee of the Northwest Territories, information relevant to licensure which would otherwise be confidential and I waive any right of disclosure of the same and agree that communication between the Registrar and the referee shall be privileged.

SIGNATURE OF APPLICANT:

DATE:

NAME OF REFEREE (PLEASE PRINT):

APPLICANT TELEPHONE/FACSIMILE #:

INSTRUCTIONS FOR REFERENCE: Your personal knowledge of this applicant is important in judging suitability for licensure. Any problems or concerns that you identify below should be explained. Please use the back of this form if required.

1. Indicate dates where, and in what capacity, you worked with the applicant. Must be within the last three years:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 2. Are you aware of any problems regarding the applicant's physical or mental health or of any alcohol or drug problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any complaints regarding the applicant from either patients or other physicians? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you know of any ethical problems the applicant has which relate to medical practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you aware of any aspects of the applicant's personality that may cause difficulties in professional interpersonal relationships with patients or other physicians? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there any reason why you would not consider the applicant to have adequate knowledge, skills, and judgement required to provide for speciality or general practice. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you any additional information with respect to the applicant's professional or ethical conduct which may affect their application for registration? | | |

SIGNATURE OF REFEREE:	DATE:
ADDRESS:	
TELEPHONE #:	FACSIMILE #:

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