120 Torbay Road, Suite W100
St. John's, NL A1A 2G8
T: (709) 726-8546
F: (709) 726-4725
E: cpsnl@cpsnl.ca

REQUEST FORM FOR INCLUSION ON ATLANTIC REGISTRY

I, _____, a physician currently licensed with the **College of Physicians and Surgeons of Newfoundland and Labrador**, request to opt-in to the Atlantic Registry.

My home College (defined by the Atlantic province where I hold an annual licence to practise medicine and the location of my usual place of practice) is **Newfoundland and Labrador**.

Once approved for the Atlantic Registry, you may only practise medicine outside of your home province once you have been issued a licence in each Atlantic province.

Atlantic Licensing Authorities Party to this Agreement:

- College of Physicians and Surgeons of New Brunswick
- College of Physicians and Surgeons of Newfoundland & Labrador
- College of Physicians and Surgeons of Nova Scotia
- College of Physicians and Surgeons of Prince Edward Island

Eligibility Requirements:

- holds a Full, General or Regular Licence with the home College;
- is not subject to a Licensing Sanction as outlined below:
    - the revocation of a physician's registration or licence;
    - the suspension of a physician's licence; or
    - the imposition of restrictions or conditions on a licence, including those conditions or restrictions agreed to by a physician in an agreement or undertaking.
- is not the subject of an open complaint which has been referred to a disciplinary panel or tribunal and a decision is pending;
- is not subject to monitoring or undergoing a quality assurance or fitness to practice review as a result of a concern raised regarding the physician's health or competency to practice medicine; and
- no other serious issues relating to the physician identified by the Registrar.

Responsibilities of the physician

- I will be responsible for obtaining appropriate credentialing/privileging with the relevant Health Authorities in each province where I practise.
- I will be required to ensure I have appropriate Canadian Medical Protective Association (CMPA) coverage in each province where I practise.
- I must become a member of the medical professional association as defined by each province.
- I will abide by the continuing professional development, currency of practice, and quality programs as required by my home College.
- I will abide by all other College policies, practice standards and guidelines, by-laws and Provincial laws in whichever province I am practising.

Complaints:

I acknowledge that any complaints made against me after being granted licensure on the Atlantic Registry will be adjudicated in the province where the patient encounter took place. I acknowledge that this information will be shared with all Atlantic Colleges.

Licence Renewal:

I acknowledge that I must complete an annual renewal with my home College, and the outcome of my renewal will be reported to all Atlantic Colleges. The details provided in my annual licence renewal may be shared with all Atlantic Colleges. By renewing my licence with my home College, I will remain on the Atlantic Registry unless I request to opt-out or no longer meet the requirements of the Registry.

Fees:

I acknowledge that I must pay a fee upon initial opt-in on the Atlantic Registry and annually as part of my licence renewal, in addition to any other annual licence fee.

Removal from the Registry:

I understand I may be removed from the Atlantic Registry if any of the following occurs at any time:

- I opt out by written notice to my home College;
- my usual place of practice is no longer within the regions governed by the Atlantic Colleges;
- I fail to meet the requirements for licensure or renewal of licensure in my home College;
- I fail to continue to meet the requirements set out in the above eligibility requirements; or
- an Atlantic College identifies an issue with my conduct, capacity, or competence that no longer qualifies me for participation in the Atlantic Registry.

Data sharing:

I acknowledge that in opting-in to the Atlantic Registry, the following data, where available, will be provided to all Atlantic Colleges and I consent to release this information:

a) Name and addresses
b) Registration/Licence number
c) Email address
d) Date of birth
e) Gender
f) Medical Identification Number for Canada (MINC)
g) Authorization to work in Canada
h) Degree, medical school and year of graduation
i) Medical credentials and/or postgraduate training
j) CMPA member number

I acknowledge that by opting-in to the Atlantic Registry, the following information may be shared among all Atlantic Colleges at any time while I am on the Atlantic Registry and I consent to release this information at any point while I am on the Atlantic Registry:

k) The date and particulars of:
   - any complaint decisions
   - undertakings;
   - restrictions or cancellation of hospital privileges known to the College;
   - open complaints; or
   - known professional litigation history including settlements, civil suit findings, statements of claim.

l) All other information, as determined by the Registrar, that may be relevant to licensing, registration, privileging, credentialing, education and/or hiring decision-making purposes, including but not limited to:
   - Registration Committee decisions
   - Results of Assessments (other than quality programs)
   - Compliance concerns (e.g. not compliant with Continuing Professional Development or

Undertakings)
- Past sponsorship or supervision concerns

In addition to any information included in the above, any information which the Registrar concludes may be relevant to the receiving jurisdictions, including information on the ethical conduct, competence or capacity of the physician.

I am aware that all Atlantic Colleges will be provided with new information meeting the descriptions above at any time while I am on the Atlantic Registry. I understand and acknowledge that I may be removed from the Atlantic Registry at any time should there be documented issues of capacity, competence, or character in any Atlantic province.

I acknowledge that I will not practise medicine in another Atlantic province, as part of this agreement, until such time that I have been issued a licence by that province's College.

☐ I hereby acknowledge and consent that I have read and accept the terms of the Atlantic Registry outlined above.

Name: _____

Licence Number: _____

Signature: _____

Date: _____

Please send your completed opt in form by email to licensing@cpsnl.ca or by fax to 709-726-4725.

College of Physicians and Surgeons of New Brunswick

Collège des Médecins et Chirurgiens du Nouveau-Brunswick

ATLANTIC REGISTRY – OPT-IN CONSENT STATEMENT

I _____ authorize and direct the College of Physicians and Surgeons of New Brunswick to provide and/or release to any other Licensing Authority, Hospital, Institution, or other entity, any and all information the College of Physicians and Surgeons in its discretion deems relevant.

Signature: _____

Date: _____

cpsnb.org

info@cpsnb.org

(506) 849-5050 | 1-800-667-4641

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COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

Registration Department
Suite 400 - 175 Western Parkway
Bedford, Nova Scotia
Canada B4B 0V1
Phone: (902) 422-5823 Toll-free: 1-877-282-7767
Fax: (902) 422-5035
registration@cpsns.ns.ca
www.cpsns.ns.ca

Declaration and Consent

In submitting this application, I understand that it is my responsibility to be familiar with and abide by the provisions of the College's policies and guidelines, available at www.cpsns.ns.ca.

I accept the College's Privacy Policy and agree to the College's use and disclosure of my personal information for the purposes set out in Part 2 of that Policy.

I understand that my responsibilities include a duty to provide my patients with reasonable access to their medical chart should I, for any reason, be absent from or leave my practice.

I confirm that I will immediately report to the College should anything occur while licensed that impacts my current capacity, competence, and character to safely and ethically practise medicine.

I accept that any information provided by me to the College may be used by the College for any regulatory purpose and shared by the College with stakeholders, including, but not limited to, the Canadian Medical Association, Dalhousie University, relevant Nova Scotia government departments and health authorities, the Medical Services Insurance Program (MSI), Doctors Nova Scotia, the Medical Identification Number for Canada (MINC), and other medical regulatory authorities. I understand that the College may seek to verify any of the information related to this application, and in so doing may seek information from other medical regulatory authorities or other institutions or persons. I hereby consent to the College doing so.

I accept the terms and conditions above.

Name:

Signature:

Date:

The College of Physicians and Surgeons of Prince Edward Island

14 Paramount Dr.
Charlottetown, PE
Canada C1E 0C7
Phone: (902)566-3861
Fax: (902) 566-3986
www.cpspei.ca

Atlantic Registry - Declaration and Consent

I, _____, understand that it is my responsibility to be familiar with and abide by the provisions of the College of Physicians and Surgeons of Prince Edward Island's (the College) policies, guidelines, and the applicable PEI legislation, available at https://www.cpspei.ca/policies/.

I accept that the below information, provided to the College, may be shared by the College to the Medical Society of PEI, Health PEI, PEI Medicare, and/or the PEI Health Recruitment and Retention team.

- E-mail address

I understand that the below information is able to be shared as determined by the Regulated Health Professions Act of PEI:

- Surname
- Given name(s)
- Practice address, phone number, fax number
- Qualifications
- Registration number, type, and status
- Registration history

I understand that the College may seek to verify any information related to this application, from other medical regulatory authorities, other institutions, or persons, and authorize the College to do so as deemed necessary.

Signature _____ Date _____