



College of Physicians and Surgeons of British Columbia

300-669 Howe Street
Vancouver BC V6C 0B4
www.cpsbc.ca

Telephone: 604-733-7758
Toll Free: 1-800-461-3008 (in BC)
Fax: 604-733-3503

Consent for Certificate of Professional Conduct

REQUEST

I, Dr. _____, _____
(Type/print full legal name) (CPSID)

request that a certificate of professional conduct be forwarded to:

Attention: _____

Organization/facility: _____

Street address: _____

City/town: _____ Province/territory/state: _____

Postal/zip code: _____ Country: _____

Phone: _____ Email: _____

CERTIFICATE OF PROFESSIONAL CONDUCT FOR ORGANIZATIONS OUTSIDE OF BRITISH COLUMBIA

If you are currently registered in the **full** or **provisional** class and are requesting that a certificate of professional conduct be issued to an organization located in a jurisdiction **outside** of British Columbia, please include an explanation below. If you plan to practise medicine in this jurisdiction, please include the duration and provide specific dates.

Physicians in the **full** class (select one):

- ☐ I will not be practising medicine in a jurisdiction outside of British Columbia.
- ☐ I will be practising medicine in a jurisdiction outside of British Columbia for less than two months. I will provide to the College a certificate of professional conduct from the medical licensing authority of that jurisdiction if I wish to resume practice in British Columbia, as required under section 25.3 of the *Health Professions Act*.
- Note:** A certificate of professional conduct will not be released to any organization outside of British Columbia until the registrant has provided answers and supporting documentation that are satisfactory to the College.
- ☐ I will be practising medicine in a jurisdiction outside of British Columbia for more than two months and am aware that my status will be changed to out of province, which will require me to contact the College before I return to practice in British Columbia to obtain a list of requirements to reinstate my licence. My final day of work in British Columbia will be: _____.
- (MM/DD/YYYY)

Physicians in the **provisional** class (select one):

If you intend to practise medicine outside of British Columbia **for any duration**, your licence will be cancelled upon your final work date in British Columbia. If you decide to return to British Columbia, note that the resolution of the Registration Committee is valid for three years from the date of its issuance, and you will be required to fulfill all stipulations of the resolution within the agreed-upon time period to be considered eligible for further licensure and registration.

- ☐ I will not be practising medicine in a jurisdiction outside of British Columbia.
- ☐ I will be practising medicine in a jurisdiction outside of British Columbia and acknowledge the above information. My final day of work in British Columbia will be: _____.
- (MM/DD/YYYY)

AUTHORIZATION AND CONSENT

1. I understand that by signing this form I give consent to the College of Physicians and Surgeons of British Columbia to disclose the following information to the organization identified above:
 - personal identifiers: physician's full legal name, CPSID and MINC (if applicable)
 - qualifications and credentials
 - registration and licensure information: current class, registration history, terms, practice conditions, licence limits
 - complaints: complaints which are open or under appeal; complaints which led to a disposition other than taking no action, but falling short of disciplinary action; former complaints that did not lead to formal action but which, in the opinion of the registrar, may reflect conduct or a pattern of conduct that should be reported in the best interest of the public
 - investigations: current and resolved, including practice investigations
 - disciplinary actions, except dismissals after a hearing, including: date of the disciplinary action, particulars, findings, remedies or sanctions
 - relevant non-disciplinary information: conditions on licence arising from health or fitness to practise, peer review or any other issue or process of a non-disciplinary nature, consent agreements or undertakings, consent withdrawal from practice or the register, restriction or cancellation of hospital privileges (if known)
 - findings of guilt, criminal and other (if known)
 - professional litigation history (if known)
 - other information considered relevant by the registrar
2. I understand why I have been asked to disclose this information, and am aware of the risks or benefits of consenting or refusing to disclose this information. I also understand that I may revoke this consent at any time by submitting a written revocation to the College of Physicians and Surgeons of British Columbia.
3. I understand that I will be notified via email to submit payment of C\$105 (\$100 fee + \$5 GST) online by logging in to the College website, if applicable.
4. I understand that processing a standard request generally takes up to 14 business days.

Full name: Dr. _____ , _____
(Type/print full legal name) (CPSID)

Street address: _____

City/town: _____ Province/territory/state: _____

Postal/zip code: _____ Country: _____

Phone: _____ Email: _____

Signature: _____ Date: _____
(Electronic signatures are not accepted) (MM/DD/YYYY)

Please return both pages of this form by email to cpc@cpsbc.ca.

The information collected in this form will be used for processing your request. If you have any questions about the collection and use of this information, please contact the College at 300-669 Howe Street, Vancouver, BC, V6C 0B4 or by phone at 604-733-7758 or 1-800-461-3008 (toll-free in BC).