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

HEALTH AUTHORITY/FACILITY

This request form is specifically for British Columbia health authorities and non-hospital medical and surgical facilities.

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: ______________

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: registrant'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 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)

Note: This request form is valid for 60 days from the date of signing. If beyond 60 days, an updated request form will be required.

Please return both pages of this form by email to the requesting health authority or non-hospital medical and surgical facility's credentialing department who will submit it to the College on your behalf.

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).