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

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

_____