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

This section does not apply to those currently registered in the educational class.

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.

Registrants 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)

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 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: ____________________ not accepted) Date: __________ (MM/DD/YYYY)

Note: This request form is valid for 60 days from the date of .9sning. If beyond 60 days, an updated request form will be required.

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

The information colTj 0ed in this form will be used for processing your request. If you have any questions about the colTj 0ion 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).