THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Institutional Request for Certificate of Professional Conduct

Please complete this electronic form, print out, sign, and
Fax to: 416-967-2654 OR
Mail to: College of Physicians and Surgeons of Ontario, 80 College Street, Toronto ON M5G 2E2
*__Please do not submit payment by email. We are unable to accept any emailed payment.__

Date of Request

Name of Institution

Attention

Street

City

Province

Postal Code

Telephone

Email

To the Registrar of the College of Physicians and Surgeons of Ontario:

Dr.

Member's CPSO number

has applied for hospital privileges at the

Consent for Release of Information

I, Dr.

a member of the College of Physicians and Surgeons of Ontario, certify that I have read the request for a Certificate of Professional Conduct and the definition of information to be included in that Certificate, printed on the document of which this Consent forms a part. I understand the nature of the information which will comprise the requested Certificate of Professional Conduct which is outlined on page 2 of this form and I further understand that the College will not release this information further to this request unless I consent to its release and evidence that consent by signing this Consent Form.

I hereby consent to the release of the Certificate of Professional Conduct defined in the document of which this Consent forms a part by the Registrar of the College of Physicians and Surgeons of Ontario to the:

Name of hospital or institution

and I request the registrar to do so.

This Consent shall be valid for six months from the day on which I signed it.

Signature of Member

Date of signature of Member

Member's mailing address:

Member's CPSO number

All fields must be completed

Telephone

Email

Information Provided in a Certificate of Professional Conduct

1. The member's qualifications as known to the College (as recorded on the Register) including date and place of primary medical qualification.

2. The class of certificate of registration held by the member and any terms and conditions attached thereto.

3. The current address of the member as recorded on the Register.

4. The specialty qualifications of the member as recorded on the Register.

5. The history of any previous disciplinary or Fitness to Practise findings as recorded on the Register.

6. The history of any terms and conditions attached to the certificate of registration as recorded on the Register.

7. Whether the member's conduct or fitness to practise is or is not the subject of an inquiry by the Discipline Committee or Fitness to Practise Committee at the time of the issuing of this Certificate.

8. Whether the member has in the six years preceding the issuance of this Certificate been the subject of proceedings before the Discipline Committee or Fitness to Practise Committee and the outcome of those proceedings.

9. Whether any restriction or cancellation of privileges by a Board of Governors of a hospital in Ontario, because of incompetence, negligence or any form of professional misconduct within the ten years preceding the date of the Certificate appears in the records of the College.

10. Any other information respecting the member which has been reported to the College and which is deemed by the Registrar to be relevant to the receiving hospital, medical school, regulatory authority or other organization.

Note: The information provided in this Certificate can be furnished to the requesting institution only where the member physician has fully completed and signed the form of consent, which forms part of this document.

Fee Payment (Certificate cannot be issued until fee of $75 is paid)

◯ **I authorize the CPSO to charge $75 to my credit card:**

◯ **I enclose cheque for $75**

◯ **Visa** ◯ **MasterCard** ◯ **American Express**

Card number

Expiry Date (MM/YY) ______

____
Cardholder signature

Please print out this form and sign above

Member's CPSO number

Member name ______

Name of Institution ______