MICs Group of Health Services

Matheson – Iroquois Falls – Cochrane

APPLICATION FOR INITIAL APPOINTMENT TO THE PROFESSIONAL STAFF

PART A: IDENTIFYING INFORMATION

Last Name:	First Name:	Middle Name(s):
Home Address: (Name and Street Number / Apartment #)		

City:	Province:	Postal Code:	Telephone Number:	Cell Phone Number:
Business Name:				
Business Address: (Name and Street Number / Suite or Room #)				Phone Number:
City:		Province:	Postal Code:	Fax Number:

OHIP Billing #:	W.S.I.B.#	Email Address:
Date of Birth:	Place of Birth:	N-95 Mask Size:

Preference for receiving correspondence: home address ☐ business address ☐ email ☐

IMPORTANT PLEASE ATTACH A PHOTOCOPY OF YOUR:

- ✓ Current CPSO membership certificate
- ✓ CMPA Membership Update OR complete Schedule C "Authorization and Consent to the Release of CMPA Membership Information"
- ✓ Current Certificate of Professional Conduct
- ✓ ATLS & ACLS cards showing expiry dates (if you will be working in the E.R.)
- ✓ Current Curriculum Vitae
- ✓ Recent photo of yourself

*** Applications missing these items will seriously DELAY the credentialing process***

PART B: QUALIFICATIONS

Ontario Licence (Please attach a copy of your College Membership Card)

Licensed to Practice in Ontario? Yes ☐ No ☐	Type:	College Registration #:
Date First Issued:	Expiry Date:	

Other Licences

Other/Previous Practice Licenses(s)? Yes ☐ No ☐	Province:	Country:	Type:
Licence/Registration #:	Date First Issued:		Expiry Date:

Malpractice Insurance Information **(Physicians – please attach a copy of your CMPA Membership Update. If you do not have a copy of your Membership Update, please complete Schedule C. Other professional staff are required to provide proof of insurance.)**

CMPA #:	Class:	Policy #:	Other Coverage – Name of Company:

PART C: EDUCATION AND TRAINING **(Please enclose copy of up-to-date curriculum vitae, including record of professional education, post-graduate training and chronology of academic and professional career, organizational positions and committee membership)**

Pre-Medical Education

		Dates	
Name of University, College, Medical School	Diploma/Degree	From	To

Medical Education **(Please attach copy of certificate)**

		Dates	
Name of University, College, Medical School	Diploma/Degree	From	To

Post Graduate Medical Training (Internships / Residencies)

		Dates	
Appointment	Institution	From	To

Post Graduate Qualifications (Certificates/Fellowships)

(Attach copy of fellowship/certification documentation)

		Dates	
Fellowship/Certificate	Specialty	From	To

Hospital Affiliations (Past and Present)

			Dates	
Name of Hospital/Location	Staff Category	Privileges	From	To

Location and Duration of all Previous Practices

Practice location	Dates	
	From	To

Professional Societies and Associations

PART D: REFERENCES

List below at least three (3) appropriate references including the Chief Executive Officer and Chief of Staff of the last hospital where you held privileges or received training, the Service Head or Head of Training Program if enrolled in a Graduate Training Program within the past three years and the Dean of Medicine of the last educational institution in which you held an appointment or were trained (applicable to recent graduates only).

Name & Title of Reference	Full address	Tel. #	Email Address

PART E: DETAILS OF REQUEST FOR APPOINTMENT

Category of Professional Staff Privileges Requested:

☐ Active ☐ Courtesy ☐ Locum Tenens ☐ Consulting

Name of Department/Program/Service/Division to which Appointment Requested:

☐ **Continuing Care Program:**
- Geriatric Medicine ☐

☐ **ER/Critical Care Program:**
- Emergency Medicine ☐

☐ **Medical Program:**
- General Practice ☐
- Internal Medicine ☐
- Neurology ☐

☐ **Mental Health Program:**
- Psychiatry ☐

☐ **Surgical Program:**
- Anesthesia ☐
- ENT ☐
- General Surgery ☐
- Obstetrics/Gynecology ☐
- Ophthalmology ☐
- Orthopedics ☐
- Urology ☐

☐ **Laboratory Medicine**

☐ **Diagnostic Imaging/Cardiopulmonary**

PART F: PROFESSIONAL LICENSING, PRIVILEGES AND MEMBERSHIP HISTORY

Questions	Yes	No
1. Has your licence to practice medicine in any jurisdiction ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis) or not renewed?		
2. Have your privileges in any hospital or healthcare institution ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis) or not renewed?		
3. Have your qualifications to practice ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis) or not renewed?		
4. Has any professional academic appointment ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis) or not renewed?		

IF THE ANSWER TO ANY OF THE ABOVE FOUR (4) QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The reasons for the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary) or non-renewal of your licence, privileges, qualifications to practice and/or academic appointment

2. The substance of both the allegations and findings in any such action, proceeding, hearing or procedure involving the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary) or non-renewal of your licence, privileges, membership and/or academic appointment

3. The date of the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary) or non-renewal of your licence, privileges, qualifications to practice and/or academic appointment and the name and address of the hospital or other institution with which you were affiliated at the time
4. Any additional information concerning such action, proceedings, hearing or procedure as you may deem appropriate or relevant.

PART G: DISCIPLINARY HISTORY

Questions	Yes	No
1. Have you ever been subject to disciplinary action by a professional college?		
2. Are there any professional misconduct proceedings, competency investigations, performance reviews, peer review-type proceedings or malpractice actions pending wherein you are a party in this province or any other province or country?		
3. Have any judgments, settlements, findings, decisions or any other determinations of any kind whatsoever been entered or made in any professional misconduct proceeding, competency investigation, performance review, peer review-type proceeding or malpractice action related to your medical practice?		

IF THE ANSWER TO ANY OF THE ABOVE THREE (3) QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The substance of both the allegations and findings in any such proceeding, investigation review or action.
2. The manner in which the proceeding, investigation, review or action was resolved (i.e. dismissed, settled, judgment entered, etc.).
3. The date and jurisdiction in which the judgment, settlement, finding, decision or determination was made.
4. Any additional information concerning such proceeding or action as you may deem appropriate or relevant.

PART H: APPLICANT'S LEGAL HISTORY

Questions	Yes	No
1. Have you ever been convicted of a crime or been the subject of a criminal proceeding in any province or country that may impact upon your suitability to be granted the privileges for which you are applying?		
2. Have you ever been a party to a civil suit related to your medical practice where there was a finding of negligence or battery or where there was an out-of-court settlement in any province or country?		

IF THE ANSWER TO ANY OF THE ABOVE TWO (2) QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The substance of the findings in any such criminal proceeding.
2. The manner in which the civil action was resolved (i.e. dismissed, settled, judgment entered, etc.) including terms of settlement.
3. The date and jurisdiction in which the judgment, settlement, finding, decision or determination was made.
4. Any additional information concerning such criminal or civil action as you may deem appropriate or relevant.

PART I: APPLICANT'S HEALTH HISTORY

Questions	Yes	No
1. Are you being treated or have you ever been treated for any medical condition, impairment, disease or illness (either physical or mental) that may impact on your present ability to practice? If yes, please see section 1.2(n) of the Standardized Credentialing Policy and complete and submit *Schedule B*.		

Note: If you are over age 70, please provide a letter of recommendation from your present Chief of Staff or Medical Director.

PART J: APPLICANT'S ACKNOWLEDGEMENT

My making of this application and signature below indicate my understanding of and consent to the following:

1. I fully recognize and agree that any misstatements in, or omissions from, this Application constitutes cause for denial of my appointment and may, at the sole discretion of the Hospital, result in a recommendation being made that my privileges be revoked or suspended or otherwise dealt with in compliance with the *Public Hospitals Act* (Ontario).
2. I acknowledge that I have read and understood the *Public Hospitals Act* (Ontario), Regulation 965 "Hospital Management" passed under the *Public Hospitals Act* (Ontario), the Hospital's By-laws, the rules and regulations, the Hospital's Standardized Credentialing Policy and other Hospital policies and the Canadian Medical Association Code of Ethics and if I am appointed to the Professional Staff of the Hospital, I agree to govern myself in accordance with the foregoing as they may be amended from time to time.
3. I acknowledge that if I am appointed to the Professional Staff of the Hospital:
   (i) any failure on my part to provide services to the Hospital in accordance with the legislation, By-laws, rules and regulations referred to in paragraph (2) above will constitute a breach of my obligations and the Hospital may, upon consideration of the individual circumstances, remove my access to any and all Hospital resources, including limiting or restricting of operating room time or take such actions as is reasonable in accordance with the *Public Hospitals Act* (Ontario), the Hospital By-laws and rules and regulations, the Hospital's Standardized Credentialing Policy and other Hospital policies; and
   (ii) the Hospital may refuse to appoint an applicant to the Professional Staff where the applicant refuses to acknowledge his or her responsibility to abide by a commitment to provide services in accordance with the privileges granted by the Board and in accordance with the *Public Hospitals Act* (Ontario), the Hospital By-laws and rules and regulations, the Hospital's Standardized Credentialing Policy and other Hospital policies.
4. I agree to appear for any meetings, hearings or interviews regarding my Application at my own expense.
5. I authorize the Hospital, its Chief Executive Officer, Chief of Staff, designated members of the Professional Staff and their representatives to contact and consult with administrators, members of professional staffs and other hospitals or institutions with which I have been associated or affiliated, including without limitation those persons listed on this Application as references and with other individuals and institutions, including past and present malpractice carriers and the Canadian Medical Protective Association, directors of post-graduate training programs or licensing and/or regulatory bodies who may have information bearing on my professional competence, character and overall qualifications for the privileges for which I am applying.

6. I consent to the inspection by the Hospital, its Professional Staff and their representatives of all records and documents of any kind or nature, including records at other hospitals, similar institutions or regulatory bodies that are material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested.
7. I agree to assist the Hospital in any way required to secure information regarding my Application and my continuing exercise of clinical privileges and membership on the Professional Staff of the Hospital.
8. I understand and agree that, as an Applicant for Professional Staff membership, I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.
9. I confirm that I have not requested privileges for any procedures for which I am not qualified. I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe and represent that I am qualified to perform all procedures for which I have requested privileges.
10. I verify that the information provided by me in this Application is true and accurate to the best of my knowledge and belief.

I HAVE BEEN ADVISED OF, AND HEREBY ACKNOWLEDGE, MY OBLIGATION TO ADVISE THE HOSPITAL IN WRITING IMMEDIATELY OF ANY NEW, DIFFERENT OR ADDITIONAL INFORMATION RELEVANT TO ANY OF THE QUESTIONS OR ITEMS OF INFORMATION REQUESTED IN THIS APPLICATION THAT AT ANY TIME COMES TO MY ATTENTION.

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Signature of Applicant Date

SCHEDULE A

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO REQUEST FOR CERTIFICATE OF PROFESSIONAL CONDUCT

Please note that, as of September 14, 2020, the College of Physicians and Surgeons (CPSO) has transitioned to a new system and no longer processes Certificate of Professional Conduct requests received via email.

As the old system has been deactivated, the hospital can no longer request your Certificate on your behalf. You are now required to submit a service request through the new member portal. Once received, a copy of your certificate must be submitted with your application for hospital privileges.

The links below were provided by the CPSO and more information can also be obtained from their website. Please be advised that Certificates of Professional Conduct may take up to 15 business days to process.

If you are a current Member and you have not yet completed your new Member Portal Account registration, please click here.

If you have an application in process and you have not yet completed your new Member Portal Account registration, please click here.

If you are new to the CPSO and would like to start an application, please click here to set up your portal account.

If you have an open application, please be assured that your information has been migrated to the new Member Portal. After you register your new Member Portal Account, you will be able to view your application.

SCHEDULE B

AUTHORIZATION AND CONSENT TO THE RELEASE OF INFORMATION FROM TREATING PHYSICIAN

(To be completed only if you are being treated or have ever been treated for any medical condition, impairment, disease or illness (either physical or mental) that might affect your present ability to practice, otherwise, leave blank).

Name of treating physician/hospital/treatment center: ____________________________________

Address: ____

I,________________________________, an Applicant for appointment to the Professional Staff of the MICs Group of Health Services (Bingham Memorial Hospital, Anson General Hospital and Lady Minto Hospital) hereby authorize and consent to you, my treating physician, to discuss with a member of the Credentials Committee of the Hospital the following medical condition, impairment, disease or illness (either physical or mental) which I feel may be relevant to my present ability to practice medicine:

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______________________________________ ______________________________________

Print Name of Physician Legibly **Signature of Physician**

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Date

SCHEDULE C

AUTHORIZATION AND CONSENT TO THE RELEASE OF CMPA MEMBERSHIP INFORMATION

TO: The Canadian Medical Protective Association
P.O. Box 8225, Station “T”
Ottawa, ON K1G 3H7

I, Dr. ____________________________________, hereby authorize the Canadian Medical Protective Association (CMPA) to fax proof of my current membership to Mr. Paul Chatelain, MICs Chief Executive Officer, MICs Group of Health Services c/o the Lady Minto Hospital in Cochrane, Ontario (fax number 705-258-2622).

Print Name of Physician Legibly	**Signature of Physician**
Date of Application	**CMPA Membership Number**
Date of Birth	**Home Address (street, box number)**
	City, Province, Postal Code

***** Please ensure you complete every field as the CMPA will not provide your certificate otherwise.**