COLLEGE OF
PHYSICIANS & SURGEONS
OF NOVA SCOTIA

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CONSENT FOR RELEASE OF INFORMATION

I, _____ , hereby give consent to the College of Family Physicians of Canada to release information and discuss my certification examination (CCFP) results and exam eligibility with the College of Physicians and Surgeons of Nova Scotia.

_____ _____

SIGNATURE OF PHYSICIAN SIGNATURE OF WITNESS

_____ _____

PRINTED NAME OF PHYSICIAN PRINTED NAME OF WITNESS

_____

DATE