



COLLEGE OF
PHYSICIANS & SURGEONS
OF NOVA SCOTIA

Registration Department

Suite 400 - 175 Western Parkway

Bedford, Nova Scotia

Canada B4B 0V1

Phone: (902) 422-5823 Toll-free: 1-877-282-7767

Fax: (902) 422-5035

Email: registration@cpsns.ns.ca

www.cpsns.ns.ca

Practice Closure Notification

A requirement when closing your practice is notifying the College in writing. Please complete the below information and return to the College via email, fax, or mail at the addresses listed above.

- 1) Name:
- 2) Licence Number:
- 3) Updated contact information (after practice closure):
 - a) Email Address:
 - b) Preferred mailing address:
- 4) Date of practice closure:
- 5) Location of Patient Medical Records (please include instructions on how patients can request their records):

- 6) Do you intend to maintain your licence after your practice closure?

- 7) Are you practising/planning to practice at least half-time (900 hours per year) after your practice closure?

Signature:

Date:



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Discontinuance of Licence Request

If you no longer require a licence in Nova Scotia, you must notify the College. Your licence may only be surrendered after you complete and return the form below and you receive consent from the Registrar.

- 1) Name:
- 2) Licence Number:
- 3) Effective date you no longer require a licence:
- 4) Reason for giving up your licence:
- 5) Do you have any health conditions that may affect your ability to practise now or in the future? If so, please provide details.

Signature:

Date:



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Currency of Practice Experience

To be considered current and to maintain currency of practice under a defined scope of practice, a physician must be engaged in regular practice, for at least 6 months of the previous 3 years.

The College defines “regular” practice as a minimum of half-time clinical practice. Half-time is calculated with the assumption that full-time practice is 1800 hours per year and therefore half-time requires a minimum of 900 hours per year.

1) Are you practising/planning to practice at least 900 hours per year after your practice closure/retirement?

2) Name:

3) Licence Number:

4) **Currency of Practice details**

A) Date you last met 'regular' practice (MM/YY):

B) Practice frequency prior to above date:

Continuous (no gaps)

Sporadic; provide details on practice dates:

C) Details on scope of practice before this date:

5) **Practice details after practice closure or retirement:**

Note: Please provide the following details regarding your practice after your practice closure or retirement date.

A) Days per month:

B) Hours per month:

C) Details on scope

of practice:

Signature

Date