COLLEGE OF
PHYSICIANS & SURGEONS
OF NOVA SCOTIA

Registration Department
400-175 Western Parkway
Bedford, NS B4B 0V1
Phone: (902) 422-5823
Toll-free: 1-877-282-7767
Fax: (902) 422-5035
www.cpsns.ns.ca

Restricted Licence (Emergency)

Restricted Licensure may be issued in the following emergent circumstances:

- When there is a declared state of emergency (e.g. pandemic, natural disaster or act of terrorism) and there is a need identified that cannot be met by a physician or physicians currently licensed in Nova Scotia; OR
- When there is an urgent or emergent need identified in the province that can best be met by licensing a physician from out of province.

In order to be eligible for this type of licensure, physicians must:

- Hold a licence for independent medical practice elsewhere in Canada; and
- Complete the application as prescribed by the Registrar (attached).

Applications will be reviewed by the Registrar on a case-by-case basis when there is a demonstrated urgent or emergent need for medical services.

The physician will be restricted to the need(s) identified in the province for which they will be providing services. If the physician wishes to practise outside of the urgent or emergent need(s) identified, they must apply for the appropriate licence type (ex. Full or Temporary licence).

More information can be found here: Restricted Licence - Emergency - Registration Policies College of Physicians & Surgeons of Nova Scotia (cpsns.ns.ca)

In order to apply for this type of licence, please request that the physician or company requesting your services submit a letter to the College outlining the need for your services, and complete the application form attached. Confirmation of receipt of your application will be sent to you by email. If you do not receive an email confirmation after two weeks from the submission of your application, please contact the College at registration@cpsns.ns.ca.

You will be provided with a username and password to access the second part of your application through Members Services on the CPSNS website. You will be able to review the received documents, the required outstanding documents and the status of your application. All of the remaining information required can be reviewed on your Member Services account.

The Member Services website will provide you with:

- a contact at the College; and
- the current status of your application; and
- the documentation that has been received to date; and
- any documentation that is still outstanding; and
- documentation expiry dates.

The Member Services website is typically updated within 2-3 business days.

COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

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Halifax, Nova Scotia
Canada B4B 0V1
Phone: (902) 422-5823 Toll-free: 1-877-282-7767 Fax: (902) 422-5035
www.cpsns.ns.ca
registration@cpsns.ns.ca

Please complete and return this fillable application form to the College by email at registration@cpsns.ns.ca. Please provide your signature on all the required documents before emailing to the College. The College will accept e-signatures. This application may also be mailed, faxed, or couriered to College. Application forms are valid for six months from the date of completion.

DATE OF APPLICATION

APPLICANT NAME

Surname, First Name, Middle Names:

PRACTICE INTENTIONS

INTENDED SCOPE OF PRACTICE

Indicate intended scope of practice:

Specialty:

PRACTICE INTENT

Intended duration of practice (you are not eligible for this paper application if practice will exceed 6 months in duration):

Intended dates of practice: to

Describe your intended practice intentions in Nova Scotia

INTENDED PRACTICE LOCATION

If known, provide details for any practice location in the province(s)/territory(ies) in which you are applying, by clicking the 'Add Intended Location' button below:

Country:
Province/Territory:
Health authority/Clinic/Physician:
Expected start date:
Street number:

PO Box or Rural Route Number:
Number suffix:
Suite/Apt/Unit:
Street name:
Street type:
Street direction:
City/Town:
Postal Code:
Telephone Number:
Fax Number:
Email address:

Country:
Province/Territory:
Health authority/Clinic/Physician:
Expected start date:
Street number:
PO Box or Rural Route Number:
Number suffix:
Suite/Apt/Unit:
Street name:
Street type:
Street direction:
City/Town:
Postal Code:
Telephone Number:
Fax Number:
Email address:

PERSONAL INFORMATION

PERSONAL INFORMATION

Surname:

First name:
Middle names:
Preferred name, if different from above:

Did you ever have a previous name?

Date of birth:

Country of birth:

Gender:

LANGUAGES SPOKEN

Are you fluent and competent to practice medicine in a language other than English? Please identify all languages in which you are:

CITIZENSHIP INFORMATION

Are you a Canadian citizen?

Do you hold permanent resident status (under the Immigration Act of Canada)?

Do you hold a valid work permit (under the Immigration Act of Canada)?

I acknowledge that if eligible for licensure, I will need to apply for a valid employment authorization (visa) under the Immigration Act (Canada) that is consistent with the class of license for which I am applying.

Yes ☐ No ☐

CONTACT INFORMATION

CONTACT INFORMATION (PRIMARY CONTACT ADDRESS, EMAIL)

Current contact information will be used to contact you during the application process. Email will be the primary method of communication.

Street number:

PO Box or Rural Route Number:

Number suffix:

Suite/Apt/Unit:

Street name:

Street type:

Street direction:

City/Town:

Country:

Province/State:

Postal/Zip code:

Preferred email address:

Confirm preferred email address:

Home Telephone Number:

Cell Phone Number:

ADDITIONAL ADDRESSES

If you have other addresses different than the one listed in the contact information section, please enter them below:

MEDICAL EDUCATION

PRIMARY MEDICAL DEGREE / DIPLOMA

Country of medical school:

Province/State:

Name of medical school:

Degree awarded:

Graduation date:

Diploma issue date:

Attendance start date:

Attendance end date:

ADDITIONAL MEDICAL SCHOOL(S)

If you were enrolled in more than one medical school to complete your primary medical degree (excluding electives), provide details below

CANADIAN CREDENTIALS

CANADIAN CERTIFICATIONS

This section refers to certification(s) you hold or you are in the process of obtaining from the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the Collège des médecins du Québec (CMQ)

Do you currently hold or in the process of obtaining Canadian certification?

Please indicate if you currently have a certification or if you are in the process of obtaining it

Certifying body:

Specialty:

Have you taken the certification examination?

Year in which eligibility expires:

Have you scheduled the certification examination?

NON-CANADIAN CREDENTIALS

NON-CANADIAN CERTIFICATIONS

If you have ever held, currently hold or in the process of obtaining certifications from countries other than Canada, provide details for each certification you hold below:

Please indicate if you currently have a certification or if you are in the process of obtaining it

Have ever held or currently hold

Country:

Certifying body:

Specialty:

Expiry date:

Certification date:

Designation:

Please indicate if you currently have a certification or if you are in the process of obtaining it

Country:

Certifying body:

Specialty:

Expiry date:

Certification date:

Designation:

POSTGRADUATE TRAINING

POSTGRADUATE TRAINING - INTERNSHIP

Did you complete an internship year?

Country in which rotation occurred:

Medical school/university/hospital name:

Rotation:

Rotation start date:

Rotation end date:

POSTGRADUATE TRAINING - SPECIALTY MEDICINE

Do you have any postgraduate specialty training?

Country of training:

Specialty/discipline:

Medical school/university/hospital name:

Position held:

Start date:

End date:

Was this period of postgraduate training performed satisfactorily as determined by your Program Director?

If you required more than the usual time to complete your program, provide details:

Country of training:

Specialty/discipline:

Medical school/university/hospital name:

Position held:

Start date:

End date:

Was this period of postgraduate training performed satisfactorily as determined by your Program Director?

If you required more than the usual time to complete your program, provide details:

EXAMS / CERTIFICATIONS

LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (LMCC)

Do you hold the Licentiate of the Medical Council of Canada (LMCC)?

Licentiate Number:

Date:

MEDICAL COUNCIL OF CANADA EXAMINATIONS

Did you take and pass the Clinical Skills Component (CSC):

Did you take and pass the MCC Evaluating Examination (MCCEE)?

Number of failed attempts:

Did you take and pass the MCC Qualifying Examination (MCCQE before 1992)?

Did you take and pass the MCC Qualifying Examination (MCCQE) Part I?

Number of failed attempts:

Did you take and pass the MCC Qualifying Examination (MCCQE) Part II?

Number of failed attempts:

Did you take and pass the National Assessment Collaboration (NAC) exam?

Number of failed attempts:

US EXAMINATIONS

Indicate whether or not you have passed any United States Medical Licensing Examinations (USMLE):

USMLE Step 1 passed date:

USMLE Step 2 CK passed date:

USMLE Step 2 CS (after June 14, 2004) passed date:

USMLE Step 3 passed date:

Indicate whether or not you have passed any Comprehensive Osteopathic Medical Licensing Examinations (COMLEX):

Indicate which other United States examination(s) you have passed:

CANADIAN ASSESSMENTS

Please indicate all Canadian medical regulatory authority practice-ready assessments you have participated in or applied to by below. Enter the intended start date for any pending Canadian medical regulatory authority practice-ready assessments, if known.

LICENCES & REGISTRATIONS

LICENCES AND REGISTRATIONS

Do you currently hold or have ever held any form of registration, licence or practice permit?

Do you currently hold a full and unrestricted independent practice licence in any Canadian jurisdiction?

Please list details of all licences you currently hold and all you have held previously below.

Country:
Issuing authority:

Date issued:
Licence/registration number:
Expiration date, if applicable:
Licence/registration type:

Country:
Issuing authority:

Date issued:
Licence/registration number:
Expiration date, if applicable:
Licence/registration type:

Country:
Issuing authority:

Date issued:
Licence/registration number:
Expiration date, if applicable:
Licence/registration type:

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Date issued:
Licence/registration number:
Expiration date, if applicable:
Licence/registration type:

Country:
Issuing authority:

Date issued:
Licence/registration number:
Expiration date, if applicable:
Licence/registration type:

Country:
Issuing authority:

Date issued:
Licence/registration number:
Expiration date, if applicable:
Licence/registration type:

PRACTICE EXPERIENCE

PRACTICE EXPERIENCE

Have you been in active medical practice or a formal programme of postgraduate medical training within the past three years?

Do you have any practice experience, not including postgraduate training?

Enter a separate Practice Experience for each position you have held in a particular location from the time you completed your postgraduate training. This includes any position you currently have.

Country:
Province/State:
City/Town:
Practice:
Specialty:
Responsibility level:
Provide details about the responsibility level and the supervision (if applicable):
Institution/facility/clinic:
Other institution/facility/clinic name:
Type/nature of duties and responsibilities:
Are you still practising at this location?
From date:
To date:

Enter a separate Practice Experience for each position you have held in a particular location from the time you completed your postgraduate training. This includes any position you currently have.

Country:
Province/State:

City/Town:
Practice:
Specialty:
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To date:

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Practice:
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From date:
To date:

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Country:
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From date:
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Country:
Province/State:
City/Town:
Practice:
Specialty:
Responsibility level:
Provide details about the responsibility level and the supervision (if applicable):
Institution/facility/clinic:
Other institution/facility/clinic name:
Type/nature of duties and responsibilities:
Are you still practising at this location?
From date, to date: to

Enter a separate Practice Experience for each position you have held in a particular location from the time you completed your postgraduate training. This includes any position you currently have.

Country:
Province/State:
City/Town:
Practice:
Specialty:
Responsibility level:
Provide details about the responsibility level and the supervision (if applicable):
Institution/facility/clinic:
Other institution/facility/clinic name:
Type/nature of duties and responsibilities:
Are you still practising at this location?
From date: to

Enter a separate Practice Experience for each position you have held in a particular location from the time you completed your postgraduate training. This includes any position you currently have.

Country:
Province/State:
City/Town:
Practice:
Specialty:
Responsibility level:
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Institution/facility/clinic:

Other institution/facility/clinic name:

Type/nature of duties and responsibilities:

Are you still practising at this location?

From: to

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Country:

Province/State:

City/Town:

Practice:

Specialty:

Responsibility level:

Provide details about the responsibility level and the supervision (if applicable):

Institution/facility/clinic:

Other institution/facility/clinic name:

Type/nature of duties and responsibilities:

Are you still practising at this location?

From: to

LANGUAGE PROFICIENCY

ENGLISH LANGUAGE PROFICIENCY

For the questions below consider the following countries to have English as a first or native language. Anguilla, Antigua and Barbuda, Australia, Bahamas, Barbados, Bermuda, British Virgin Islands, Canada, Dominica, Grenada, Grenadines, Ireland, Jamaica, New Zealand, Singapore, South Africa, St. Kitts and Nevis, St. Lucia, St. Vincent, Trinidad and Tobago, United Kingdom, United States of America, US Virgin Islands

Was your undergraduate medical education taken in English in one of the countries that have English as a first and native language? List all that apply.

DECLARATIONS

DECLARATION NOVA SCOTIA

I hereby declare that the information provided on this form is complete, accurate and factually correct.

I accept the terms and conditions above.

Printed Name:

Date:

Signature

Note: Please provide details for any 'yes' responses in the form available at the end of these questions. If your application is received with incomplete information, processing may be delayed.

BACKGROUND

ATTESTATION

Do you confirm the information in this section is complete, true, accurate and up to date?

CRIMINAL OFFENCES

Have you ever been charged with or convicted of a criminal or similar offence?

INFORMATION ABOUT LICENCES, PERMITS AND APPLICATIONS

Have you ever had an application for a medical licence, certificate of registration, or permit to practice, rejected, refused or denied?

Have you ever been refused renewal of a medical licence, certificate of registration or permit to practice?

Have you ever had a medical licence, certificate of registration or permit to practice:

Revoked:

Suspended:

Restricted in any way:

Subjected to conditions of any kind:

Limited in any way:

Subjected to any other adverse action:

MEDICAL REGULATORY AUTHORITIES ACTIONS RELATED TO PROFESSIONAL CONDUCT AND COMPETENCE

Are you now the subject of a complaint or request for investigation to a medical licensing or regulatory authority?

Have you ever had your right to bill restricted or removed by a health care paying agency?

Have any past complaints resulted in any of the following actions by a medical licencing or regulatory authority. Indicate all that apply.

A formal investigation:

A disciplinary proceeding:

A review of your conduct, competence, capacity or fitness to practice:

An audit of your practice:

An assessment of your practice:

With special support measures:

Are you currently subject to a review of any of the following (whether arising from a complaint or otherwise):

Your conduct (professional, unbecoming or misconduct:

Your competence:

Your capacity:

Your fitness to practice:

Has there ever been a review of any of the following (whether arising from a complaint or otherwise):

Your conduct:

Your competence:

Your capacity:

Your fitness to practice:

In connection with any inquiry, investigation or proceeding relating to your professional conduct, competence, capacity, or to any other aspect of your medical practice, have you ever voluntarily:

Restricted your medical licence, certificate of registration or permit to practice?

Resigned or surrendered your medical licence, certificate of registration or permit to practice?

Withdrawn from your practice of medicine?

Entered a plea of “no contest”?

Have your privileges or legal authority to purchase, prescribe, possess, or dispense narcotic or other restricted drugs ever been:

Restricted:

Reduced:

Withdrawn:

Voluntarily surrendered:

Are your privileges or legal authority to purchase, prescribe, possess, or dispense narcotic or other restricted drugs currently:

Restricted:

LEGAL OR INSURANCE ACTIONS RELATED TO PROFESSIONAL CONDUCT

With respect to your practice of medicine or your professional activities, are you currently or have you ever been subject to any of the following actions:

Legal action:

Insurance claim:

Other claim:

Has a court ever made a finding against you arising from any legal action, claim or other proceeding that was in any way related to your practice of medicine or your professional activities?

With respect to a criminal offence or an offence under any narcotic or controlled substance legislation, have you ever:

Been convicted:

Been found guilty:

Pleaded guilty:

Been charged:

Pleaded no contest:

Filed any plea similar to "pleaded guilty" or "pleaded no contest":

Entered a diversion program:

Have you ever been charged with or convicted or found guilty of, pleaded guilty to, pleaded no contest to, or filed any similar plea for any of the following offences in any jurisdiction:

Illegal use of a professional title:

Illegal practice of a profession:

Have you ever had, in connection with your practice of medicine, a negligence claim made against you, been sued for negligence, had a negligence claim paid on your behalf, or paid such a claim yourself?

Have you been sued in a civil action relating to fraud?

Have you ever been named as a defendant in a civil action?

Have you ever been, or are you now, the subject of any restriction, termination or suspension of your ability to work in any profession or occupation, in any setting?

Do you have any pending criminal charges, whether in Canada or elsewhere?

Do you have pending against you any other type of charges or other proceedings for statutory offences relevant to your practice of medicine or any other profession, (e.g. charges under the Controlled Drugs and Substances Act, charges under the Food and Drug Act, charges of fraud or proceedings for a restraining order)?

Has a court ever issued a restraining order against you?

HOSPITAL, HEALTH FACILITY, OR HEALTH AUTHORITY ACTIONS

Have you ever been denied any of the following in a hospital or other health facility:

Privileges:

Reappointment or reinstatement of privileges:

Appointment to medical staff:

Reappointment to medical staff:

Has a hospital or other health facility ever changed your privileges in any of the following ways:

Suspended:

Limited-for-cause:

Restricted or reduced:

Revoked or removed:

Cancelled:

Withdrawn:

Not renewed:

Have you ever voluntarily given up, relinquished, changed, or agreed not to exercise your privileges, or resigned from a health authority, hospital or other health facility, at any of the following times:

While facing allegations of professional misconduct, malpractice, incompetence or incapacity:

During, subsequent to, or in lieu of an inquiry, investigation or review that was in any way related to your professional conduct, competence, capacity or any other aspect of your medical practice:

While disciplinary action was pending:

Within the last three years, have you been the subject of any review of your conduct, competence, or capacity or fitness to practise, whether arising from a complaint or otherwise, by an entity other than a body with authority to regulate the practice of medicine or any other profession?

CONDUCT DURING UNDERGRADUATE MEDICAL EDUCATION

During your undergraduate medical education were you ever the subject of any of the following actions conducted through a hospital or other health facility, in any jurisdiction:

Complaint:

Inquiry or investigation:

Restriction of the scope of your medical practice:

Disciplinary action:

Dismissal:

During your undergraduate medical education, have you ever:

Withdrawn:

Been expelled:

Been suspended:

Been put on probation:

Required remediation by a medical school or educational institution for any reason:

Resigned in lieu of an inquiry:

Were you ever the subject of any type of investigation, inquiry or proceeding by a medical school or educational institution for any of the following reasons:

Academic misconduct or misconduct of any type:

Issues related to your conduct, competence, character, capacity or fitness to practice:

Were you ever investigated or sanctioned by any academic or research body for misconduct of any type or for any violation of academic policy?

During your undergraduate medical education, did you ever:

Take a leave of absence from or otherwise interrupt your undergraduate medical education for three (3) months or longer?

Transfer from one undergraduate medical educational program to another?

CONDUCT DURING POSTGRADUATE MEDICAL TRAINING

During any of your internship, residency, fellowship, postgraduate training, educational or other institutional training, have you ever been:

Investigated:

Suspended:

Removed, dismissed, expelled, or prematurely terminated from the program:

Put on probation:

Put on remediation:

Subject to revocation of your training appointment:

Advised to withdraw:

Otherwise disciplined:

Have you ever withdrawn or resigned from any of your postgraduate medical training?

At any time during an internship, residency, fellowship, postgraduate training, educational or other institutional training, have you ever:

Taken a leave of absence from or otherwise interrupted your postgraduate medical training program for three (3) months or longer:

Transferred from one postgraduate medical training program to another without having completed the first program:

Begun a medical training program of any description that you did not complete:

ABSENCES FROM PRACTICE

Have you ever ceased, interrupted, or been away from practice for three (3) months or longer?

FITNESS TO PRACTICE

Do you have, or has anyone ever advised you that you have, a physical, cognitive, mental and/or emotional condition which in any way may reasonably be expected to pose a risk of harm to patients or negatively impact your work as a physician?

Have you ever had, or have you ever been advised that you had, a physical, cognitive, mental and/or emotional condition which in any way may, should it reoccur, reasonably be expected to pose a risk of harm to patient or negatively impact your work as a physician?

Please provide additional details to any 'yes' responses in the boxes below. Information on different 'yes' responses should be entered in separate boxes.

Category:	Details:
Category:	Details:
Category:	Details:
Category:	Details:

Please provide additional details to any 'yes' responses in the boxes below. Information on different 'yes' responses should be entered in separate boxes.

Category:	Details:
Category:	Details:
Category:	Details:
Category:	Details:

DECLARATIONS

DECLARATION NOVA SCOTIA

Declaration and Consent

In submitting this application, I understand that it is my responsibility to be familiar with and abide by the provisions of the College's policies and guidelines, available at www.cpsns.ns.ca.

I accept the College's Privacy Policy and agree to the College's use and disclosure of my personal information for the purposes set out in Part 2 of that Policy.

I understand that my responsibilities include a duty to provide my patients with reasonable access to their medical chart should I, for any reason, be absent from or leave my practice.

I confirm that I will immediately report to the College should anything occur while licensed that would alter my responses to any of the questions contained in this application.

I accept that any and all information provided by me to the College in the course of this licensing application may be used by the College in the course of any regulatory process of any regulatory authority, and I consent to the College disclosing this information for this purpose.

I understand that the College may seek to verify any of the information related to this application, and in so doing may seek information from other medical regulatory authorities or other institutions or persons. I hereby consent to the College doing so.

I declare that the information provided in this application for licence is true and accurate, to the best of my knowledge. I make this declaration knowing that the provision of false information in the application, whether false by commission or omission, may be considered professional misconduct and may result in the revocation of any licence that has been issued to me.

I accept the terms and conditions above.

Printed Name: Date:

Signature