

# PHYSICIAN ASSISTANT LICENCE APPLICATION

As of April 1, 2024, all practising Physician Assistants in Nova Scotia must be licensed by the College of Physicians and Surgeons of Nova Scotia.

As of April 1, 2024, the Medical Act Regulations have been amended conferring upon the College of Physicians and Surgeons of Nova Scotia the responsibility and authority to regulate Physician Assistants within the province.

All new Physician Assistants intending to practice in Nova Scotia must complete the enclosed application.

## HOW TO APPLY

### STEP 1

After obtaining a letter of offer from Nova Scotia Health, submit the application form enclosed with your identifying information, Nova Scotia practice intentions, training, licence, and employment history, and background questions. Applications can be submitted by:

#### MAIL

Registration Department  
Suite 400 – 175 Western Parkway  
Bedford, Nova Scotia, Canada B4B 0V1

#### EMAIL

[registration@cpsns.ns.ca](mailto:registration@cpsns.ns.ca)

#### FAX

902-422-5035

### STEP 2

One of the College's Registration Agents will contact you with access to our Member Services portal, where you can find information on the remaining documents required to complete your application for licensure. They will be your dedicated Agent and will be able to assist you throughout this process.

### STEP 3

Once all documents have been received, your application will be sent for final review and approval. This process may take 1–3 business days. Once complete, you will receive confirmation of your licence via email.

**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 | [cpsns.ns.ca](http://cpsns.ns.ca)

# APPLICATION

## 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 [cpsns.ns.ca](https://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 information provided by me to the College may be used by the College for any regulatory purpose or shared by the College with stakeholders, including but not limited to the Canadian Medical Association, Dalhousie University, relevant Nova Scotia government departments and health authorities, the Medical Services Insurance Program (MSI), Doctors Nova Scotia, the Medical Identification Number for Canada (MINC), Nova Scotia Podiatry Association, other medical regulatory authorities or professional associations, etc.

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 denial of licensure or the revocation of any licence that has been issued to me.

I accept the terms and conditions above

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Name

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Date

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Signature

## PERSONAL INFORMATION

\_\_\_\_\_  
Last name (surname/family name)

\_\_\_\_\_  
First name

\_\_\_\_\_  
Middle name

\_\_\_\_\_  
Previous surname (if applicable)

\_\_\_\_\_  
Preferred name, if different from above

\_\_\_\_\_  
Country of birth

\_\_\_\_\_  
Date of birth

### GENDER IDENTITY

Female

Male

### PRONOUNS

The college makes every effort to ensure we address you by way of your appropriate gender pronouns.

\_\_\_\_\_  
Pronouns

### LANGUAGES SPOKEN

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

\_\_\_\_\_  
Languages

### CITIZENSHIP INFORMATION

Canadian

Permanent resident (landed immigrant)

Work permit

## CONTACT INFORMATION

\_\_\_\_\_  
Street address/PO Box/rural route/lot #

\_\_\_\_\_  
City/Town

\_\_\_\_\_  
Province

\_\_\_\_\_  
Postal code

\_\_\_\_\_  
Country

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Cell phone number



## UNDERGRADUATE EDUCATION

\_\_\_\_\_  
Name of institution

\_\_\_\_\_  
Country

\_\_\_\_\_  
Name of program

\_\_\_\_\_  
Attendance start date

\_\_\_\_\_  
Attendance end date

\_\_\_\_\_  
Degree awarded date

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

## PHYSICIAN ASSISTANT EDUCATION

\_\_\_\_\_  
Name of institution

\_\_\_\_\_  
Country

\_\_\_\_\_  
Name of program

\_\_\_\_\_  
Attendance start date

\_\_\_\_\_  
Attendance end date

\_\_\_\_\_  
Degree awarded

\_\_\_\_\_  
Degree awarded date

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

## CERTIFICATION

Please provide details on your Physician Assistant certification.

### PHYSICIAN ASSISTANT CERTIFYING COUNCIL OF CANADA (PACCC)

\_\_\_\_\_  
Physician Assistant Entry to Practice Certification Examination date

\_\_\_\_\_  
Canadian Certified Physician Assistant (CCPA) certification date

\_\_\_\_\_  
Certification number

### NATIONAL COMMISSION OF CERTIFICATION OF PHYSICIAN ASSISTANTS (NCCPA) IN THE USA

\_\_\_\_\_  
Examination date

\_\_\_\_\_  
Physician Assistant-Certified (PA-C) date

\_\_\_\_\_  
NCCPA number

## LICENCES & REGISTRATIONS

Please list all jurisdictions where you have ever held or currently hold a licence or registration:

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Issuing authority

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Country

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Date issued

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Licence/registration type

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Licence/registration number

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Expiry date (if applicable)

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Issuing authority

---

Country

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Date issued

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Licence/registration type

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Licence/registration number

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Expiry date (if applicable)

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Issuing authority

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Country

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Date issued

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Licence/registration type

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Licence/registration number

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Expiry date (if applicable)

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Issuing authority

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Country

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Date issued

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Licence/registration type

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Licence/registration number

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Expiry date (if applicable)

## EMPLOYMENT

Please list each place of employment since completion of Physician Assistant education.

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Institution/facility/clinic

Province/State

Country

Start date

End date

Nature of responsibilities

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Institution/facility/clinic

Province/State

Country

Start date

End date

Nature of responsibilities

---

Institution/facility/clinic

Province/State

Country

Start date

End date

Nature of responsibilities

---

Institution/facility/clinic

Province/State

Country

Start date

End date

Nature of responsibilities

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## BACKGROUND QUESTIONNAIRE

### CRIMINAL OFFENCES

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Have you been charged or convicted of criminal charges in any jurisdiction or charged under the *Criminal Code* or the *Controlled Drug and Substances Act*?

Yes

No

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Have you ever been charged or convicted with illegal practice of a profession or illegal use of a professional title?

Yes

No

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If you responded yes to any of the above questions, please provide an explanation below:

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## EDUCATIONAL PROGRAMS

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|  |     |    |
|--|-----|----|
| Have you been disciplined or subject to a disciplinary process within an educational program?  | Yes | No |
| Have you been placed on academic probation, been the subject of any complaint(s), or been required to undergo remediation during an educational program? | Yes | No |
| Have you taken a leave of absence from an educational program of three months or longer?   | Yes | No |

If you responded yes to any of the above questions, please provide an explanation below:

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## LICENSURE OR MEMBERSHIP

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|  |     |    |
|--|-----|----|
| Has there been a complaint against you before any medical regulatory, licensing authority, or professional association?  | Yes | No |
| Were you or are currently subject to restrictions or conditions of any kind on your licence or membership to practise?   | Yes | No |
| Have you had a concern or complaint resolved or addressed, formally or informally, with any regulatory, licensing authority, or professional association? Such resolutions may include settlement agreements, undertakings or other forms of resolution. | Yes | No |
| Have you been denied licensure or membership by any regulatory authority, licensing authority or membership with a professional association?   | Yes | No |
| Have you ever had licensure or membership suspended or revoked by any regulatory authority, licensing authority or professional association?   | Yes | No |

If you responded yes to any of the above questions, please provide an explanation below:



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## LEGAL ACTIONS

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|  |     |    |
|--|-----|----|
| Has there been civil litigation (lawsuit) brought against you as a Defendant regarding your practice?  | Yes | No |
| Has a judgement been rendered against you, or have you agreed to an out of court settlement on any legal action pertaining to your practice? | Yes | No |
| Has a court ever issued a restraining order against you?   | Yes | No |

If you responded yes to any of the above questions, please provide an explanation below:

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## PRACTICE AND PRIVILEGES

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|  |     |    |
|--|-----|----|
| Have you changed or left your practice, or been dismissed from your employment, for concerns relating to your conduct, character or matters of professional competence?  | Yes | No |
| Have your privileges to practise or terms of employment in a health care facility or health authority been revoked, withdrawn, altered or not renewed as a result of concerns relating to your conduct, character or matters of professional competence? | Yes | No |
| Have you resigned your privileges for any reason or voluntarily altered your privileges by way of an undertaking?  | Yes | No |
| Have you ever ceased, interrupted, or been away from practice for three months or longer?  | Yes | No |

If you responded yes to any of the above questions, please provide an explanation below:

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## HEALTH & WELLNESS

Have you ever had, or been advised that you had, 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 Assistant. The College would like to advise you of the following supports that are available should you require support at any point in your licensure in Nova Scotia.

The College itself has a Health Program that oversees the monitoring of registrants with health concerns that might impact their fitness to practice. This is a voluntary program that looks at health issues with a wellness lens and helps ensure you have appropriate supports in place. You are able to self-refer to this program, by emailing the College's Physician Support Officer at [physiciansupport@cpsns.ns.ca](mailto:physiciansupport@cpsns.ns.ca).

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|   |            |           |
|---|------------|-----------|
| Do you have, or has anyone ever advised you that you have, a physical, cognitive, mental and/or emotional condition which poses a risk of harm to patients or impairs your work as a Physician Assistant? | <b>Yes</b> | <b>No</b> |
|---|------------|-----------|

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|   |            |           |
|---|------------|-----------|
| Have you been involved with a health program for a physical, cognitive, mental and/or emotional condition which poses a risk of harm to patients or impairs your work as a Physician Assistant? | <b>Yes</b> | <b>No</b> |
|---|------------|-----------|

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If you responded yes to any of the above questions, please provide an explanation below: