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
www.cpsns.ns.ca

STREAMLINED APPLICATION FOR LICENSURE IN NOVA SCOTIA

ARE YOU FULLY LICENSED IN ANOTHER CANADIAN JURISDICTION AND INTERESTED IN PRACTISING IN NOVA SCOTIA?

You may qualify for our streamlined application for licensure if you have a regular, general or full licence to practise in a Canadian province or territory with:

- no interim or permanent restrictions or conditions;
- no current undertakings with other Colleges; and
- no disciplinary sanctions on your record

If you hold a regular, general or full licence in either **New Brunswick, Prince Edward Island, or Newfoundland and Labrador**, you may be interested in opting on to the Atlantic Registry instead. More information can be found here.

HOW TO APPLY:

STEP 1

Submit the application form attached with your identifying information, Nova Scotia practice intentions, postgraduate training, licence, and practice history, and background questions.

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.

What additional documents are required?

- Certificate of Professional Conduct (CPC)
  - Please contact your licensing authority to request a CPC. This will be issued electronically directly to our College through agreements between all Canadian MRA's.
- Canadian Medical Protective Association (CMPA) coverage
  - Please contact CMPA and request coverage for Nova Scotia. Once processed, please provide your updated Statement of Protection.
- Criminal Record Check
  - The College uses an organization called CSI Screening. Requests for criminal record checks can be made online, and CSI will provide these to the College electronically through a secure portal.
  - Wondering about process time? Only a Canadian criminal record check is required and CSI can process these requests within 24-48 hours.
- Work authorization
  - Please provide a copy of your Canadian passport or Canadian permanent resident card

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  - If you are on a work permit, please provide a copy of the permit along with a government-issued photo ID
- Consent forms (attached)
  - CPD – Satisfactory participation and enrolment in continuing professional development is an important aspect of maintaining and enhancing competence throughout your career. Please provide your enrolment details and consent for information sharing amongst programs.
  - Information sharing – To reduce duplication and help streamline your application for privileges, please sign this consent form to allow for sharing of your licensure application file with Nova Scotia Health (NSH) or the IWK

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.

A Note about Licensure fees

The Registration fee and your first year annual licence fee will be waived under the Patient Access to Care Act (PACA). Your first payment of fees will be the annual licence fee for the next calendar year if you are applying for renewable licensure.

THANK YOU FOR YOUR INTEREST IN PRACTISING IN NOVA SCOTIA AND WE LOOK FORWARD TO WELCOMING YOU HERE.

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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 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 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), other medical regulatory authorities, 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.

Signature

Date

Name

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MEDICAL IDENTIFICATION NUMBER FOR CANADA (MINC)

The medical identification number for Canada (MINC) is a unique, lifetime identifier for all individuals who enter the Canadian medical education or practice system. MINC#NIMC is a not-for-profit organization incorporated by the Federation of Medical Regulatory Authorities of Canada and the Medical Council of Canada for the purpose of administering the Medical Identification Number of Canada (MINC) system. The MINC system provides a reliable means of identifying individuals by sharing the MINC number and necessary registration information within the healthcare system for approved purposes. More information regarding MINC and its privacy practices can be found here.

The College utilizes a registrant's MINC# to source verify, electronically, whether registrants are compliant with their continuing competency requirements. Where registrants do not have a MINC, College staff must undertake significant extra manual work to verify a registrant's compliance with their continuing professional development requirements.

In order to facilitate the accurate and reliable identification of physicians and surgeons across Canada, the College will submit necessary registration information (your name, gender, date and country of birth, medical degree information and College account number) to MINC#NIMC.

☐ I accept that my data will be sent to MINC#NIMC for the purposes of being registered in the MINC system

Signature

Date

Name

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PERSONAL INFORMATION

SURNAME:

FIRST NAME:

MIDDLE NAME:

PREFERRED NAME, IF DIFFERENT FROM ABOVE:

DID YOU EVER USE A PREVIOUS NAME?

DATE OF BIRTH:

COUNTRY OF BIRTH:

GENDER

Please select from the list below:

THE COLLEGE MAKES EVERY EFFORT TO ENSURE WE ADDRESS YOU BY WAY OF YOUR APPROPRIATE GENDER PRONOUNS. WHAT ARE YOUR PRONOUNS?

PRONOUNS

Please the option that applies to you:

If other, please identify:

LANGUAGES SPOKEN

Are you fluent and competent to practice medicine in a language other than English? Yes ◯ No ◯

Please identify all languages in which are fluent:

CITIZENSHIP INFORMATION

Please select the option that applies to you:

Please select:

CONTACT INFORMATION

EMAIL ADDRESS:

MAILING ADDRESS:

CITY/TOWN:

COUNTRY:

POSTAL/ZIP CODE:

CELL PHONE NUMBER:

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PRACTICE INTENTIONS IN NOVA SCOTIA

Intended start date:

Intended duration: Please select:

Intended end date (if applicable)

Intended discipline of practice: Please select:

Describe your intended scope of practice in Nova Scotia:

A Word about Currency of Practice:
To practise medicine in Nova Scotia, physicians must be current in practice. The College considers a physician to be current if they have engaged in clinical practice for at least 450 hours in the previous 3 years (this approximates 3 months of equivalent full-time practice in the previous 3 years. Please refer to the College's ***Currency of Practice*** policy for more information.)

Have you practiced at least 450 clinical hours in the last 3 years in the scope you are intending to practice in Nova Scotia?

◯ Yes ◯ No

If no, please provide a description of your current scope of practice, and the date of your last practice in the scope you intend to practice in Nova Scotia:

INTENDED PRACTICE LOCATION

FACILITY NAME:

ADDRESS:

CITY/TOWN:

COUNTRY:

POSTAL/ZIP CODE:

OFFICE PHONE NUMBER:

OFFICE FAX NUMBER:

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MEDICAL DEGREE

COUNTRY:

MEDICAL SCHOOL/UNIVERSITY:

QUALIFICATION:

DATE:

EXAMINATIONS

DO YOU HOLD THE LICENTIATE OF THE MEDICAL COUNCIL OF CANADA (LMCC)? ◯ Yes ◯ No

If yes, please provide the following:

LMCC number: Registration date:

HAVE YOU COMPLETED ANY OF THE FOLLOWING EXAMS?

UNITED STATES MEDICAL LICENSING EXAM (USMLE) STEPS 1, 2 AND 3 ◯ Yes ◯ No

Dates

FEDERATION LICENSING EXAMINATION (FLEX) COMPONENTS 1 AND 2 ◯ Yes ◯ No

Dates

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) PARTS I, II, AND III ◯ Yes ◯ No

Dates

THE COMPREHENSIVE OSTEOPATHIC LICENSING EXAMINATION (COMPLEX-USA) LEVELS 1, 2 AND 3

◯ Yes ◯ No

Dates

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POSTGRADUATE TRAINING

PLEASE LIST ALL POSTGRADUATE TRAINING PROGRAMS THAT YOU HAVE COMPLETED:

COUNTRY:

MEDICAL SCHOOL/UNIVERSITY:

DISCIPLINE:

POSITION HELD:

START DATE:

END DATE:

COUNTRY:

MEDICAL SCHOOL/UNIVERSITY:

DISCIPLINE:

POSITION HELD:

START DATE:

END DATE:

COUNTRY:

MEDICAL SCHOOL/UNIVERSITY:

DISCIPLINE:

POSITION HELD:

START DATE:

END DATE:

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LICENCES & REGISTRATIONS

PLEASE LIST ALL JURISDICTIONS WHERE YOU CURRENTLY HOLD AN ACTIVE LICENCE OR REGISTRATION:

COUNTRY:
PROVINCE/STATE
ISSUING AUTHORITY:
DATE ISSUED:
LICENCE/REGISTRATION NUMBER:
LICENCE/REGISTRATION TYPE:
Are you currently practising in this jurisdiction? ◯ Yes ◯ No

COUNTRY:
PROVINCE/STATE
ISSUING AUTHORITY:
DATE ISSUED:
LICENCE/REGISTRATION NUMBER:
LICENCE/REGISTRATION TYPE:
Are you currently practising in this jurisdiction? ◯ Yes ◯ No

COUNTRY:
PROVINCE/STATE
ISSUING AUTHORITY:
DATE ISSUED:
LICENCE/REGISTRATION NUMBER:
LICENCE/REGISTRATION TYPE:
Are you currently practising in this jurisdiction? ◯ Yes ◯ No

COUNTRY:
PROVINCE/STATE
ISSUING AUTHORITY:
DATE ISSUED:
LICENCE/REGISTRATION NUMBER:
LICENCE/REGISTRATION TYPE:
Are you currently practising in this jurisdiction? ◯ Yes ◯ No

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BACKGROUND QUESTIONNAIRE:

CRIMINAL OFFENCES:

1. 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**

COMPLAINTS:

2. Is there an open complaint against you before any medical regulatory or licensing authority?

◯ **Yes** ◯ **No**

LEGAL ACTIONS:

3. Has a judgement been rendered against you, or have you agreed to an out of court settlement on any legal action pertaining to your medical practice?

◯ **Yes** ◯ **No**

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EMPLOYMENT STATUS:

4. 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**

PRIVILEGES:

5. Have there been changes to your privileges (including but not limited to revocation, withdrawal, resignation, or alteration) as a result of concerns relating to your **conduct, character or matters of professional competence**?

◯ **Yes** ◯ **No**

HEALTH & WELLNESS:

6. 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?

◯ **Yes** ◯ **No**

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If you 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, I 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 Physician 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 physician 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 Colleges Physician Support Officer at physiciansupport@cpsns.ns.ca.

Outside of the College, Doctors Nova Scotia has a Professional Support Program that may be of interest to you. More information is available on their website: https://doctorsns.com/benefits/professional-support.

Licensure:

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

◯ **Yes** ◯ **No**

8. Have you ever had a medical licence, certificate of registration, or permit to practice revoked, suspended or restricted in any way?

◯ **Yes** ◯ **No**

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CONSENT FORM - INFORMATION SHARING

The College of Physicians and Surgeons of Nova Scotia ("CPSNS") has developed a Centralized Registration Process that streamlines the provision of application and licensing information to stakeholders, including but not limited to certifying colleges, health authorities, medical facilities, faculties of medicine and privileging bodies.

I consent to the CPSNS releasing to stakeholders any information provided in support of this application, including my application documents, Certificates of Professional Conduct, Reference Forms, Criminal Record Checks, Litigation information and CPSNS Registration Committee decisions.

Please select the organization(s) that you request the CPSNS provide your application/registration information to:

☐ ***Nova Scotia Health***
☐ ***IWK Health Centre***

_____ _____
Full Name of Physician Signature of Physician

_____
Date

_____ _____
Witness Signature of Witness

_____
Date

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Continuing Professional Development Program

Introduction

A commitment to maintaining and enhancing competence and practice performance is a pillar of medical professional self-regulation. The College of Physicians and Surgeons of Nova Scotia (the College) requires its members to participate in the continuing professional development programs of either the College of Family Physicians of Canada (CFPC) Mainpro+ program, the Royal College of Physicians and Surgeons of Canada (Royal College) Maintenance of Competence (MOC) program or a member board of the American Board of Medical Specialties.

Name: _____ CPSNS Licence # _____
(Please print) (If known)

In which of the following continuing professional development programs do you currently participate?

☐ **College of Family Physicians of Canada Mainpro+ Program**

CFPC ID # _____

MAINPRO Cycle information:
Cycle Start: _____ (month/year) Cycle End: _____ (month/year)

☐ **Royal College of Physicians and Surgeons of Canada MOC Program**

Royal College ID #_____

MOC Cycle information:
Cycle Start: _____ (month/year) Cycle End: _____ (month/year)

☐ **Member Board of the American Board of Medical Specialties**

Member Board _____

National Provider Identifier (NPI): _____

Effective date: _____ (month/year) Reverification date: _____ (month/year)

Consent

By signing below, I provide formal consent to the College of Physicians and Surgeons of Nova Scotia to exchange information with the respective certifying college (CFPC or Royal College) or relevant member board of the American Board of Medical Specialties. This information pertains solely to my participation in the professional development program or maintenance of certification. (Further information about this consent is attached.)

_____ _____

Signature Date

Please return this form by fax to (902) 422-5035 or by e-mail at registration@cpsns.ns.ca.

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Information on Consent to Exchange Information with the College of Family Physicians of Canada, or the Royal College of Physicians and Surgeons of Canada on Continuing Professional Development (CPD) and a Member Board of the American Board of Medical Specialties on Maintenance of Certification (MOC).

Introduction

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College of Family Physicians of Canada (CFPC) Mainpro+ Program

If you are enrolled in the College of Family Physicians of Canada (CFPC) Mainpro+ program, or if you will be enrolling, your consent authorizes the CFPC to provide any information relevant to your participation in the Mainpro+ program, and any information that the College of Physicians and Surgeons of Nova Scotia may request pertaining to your participation in the Mainpro+ program. This authorization will continue unless you revoke it in writing.

Royal College of Physicians and Surgeons of Canada (Royal College) Maintenance of Certification (MOC) Program

If you are enrolled with the Royal College of Physicians and Surgeons of Canada (Royal College) Maintenance of Certification (MOC) program or you will be enrolling, your consent authorizes the Royal College to provide any information relevant to your participation in the MOC program, and any information that the College of Physicians and Surgeons of Nova Scotia may request pertaining to your participation in the MOC program. This authorization will continue unless you revoke it in writing.

Member Board of the American Board of Medical Specialties

If you are enrolled with a member board of the American Board of Medical Specialties Maintenance of Certification (MOC) program or you will be enrolling, your consent authorizes the relevant member board to provide any information relevant to your participation in the MOC program, and any information that the College of Physicians and Surgeons of Nova Scotia may request pertaining to your participation in the MOC program. This authorization will continue unless you revoke it in writing.