



MEMBERSHIP APPLICATION/ REACTIVATION FORM

For membership information, go to the CMPA website (www.cmpa-acpm.ca, go to Membership) or contact us at 613 725-2000 or 1 800 267-6522. This form can be completed online if you pay by pre-authorized debit.

Instructions: Please print and use ink. Return your fully completed Application/Reactivation form by fax **OR** mail; choose only one method to avoid duplication and processing delays. Please ensure your payment accompanies your completed application form.

All applicants must complete Sections A and C.

Were you previously a CMPA member? Yes No If yes, member number

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Name _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Mailing address _____
(APT/SUITE, STREET NUMBER AND NAME, NOT NAME OF BUILDING)

(CITY) (PROVINCE/TERRITORY) (POSTAL CODE) (COUNTRY)

Telephone _____
(HOME) (BUSINESS) (CELL PHONE) (PAGER)

Fax _____ Email address _____

Gender M F Date of birth _____
(mm/dd/yyyy)

Preferred language of correspondence English French

SECTION A – Must be completed by all applicants.	
Your provision of Personal Information to the CMPA means that you agree and consent that we may collect, use and disclose your Personal Information in accordance with the CMPA Privacy Policy. The enclosed brochure entitled “The CMPA, Privacy and You” contains specific privacy policy highlights. A copy of the CMPA Privacy Policy can be found on the CMPA’s website www.cmpa-acpm.ca (go to Membership > Privacy Policy) or may be obtained by contacting the CMPA.	
1	Date you wish membership to start _____. (mm/dd/yyyy) Your membership will only begin once we receive your completed application form, all necessary documents and payment arrangements. For first time applicants, the minimum period of membership in a calendar year is two months.

SECTION A – continued

2 Province of work and type of work:

The CMPA determines membership fees based on your type of work AND on the province/territory where you work or train (refer to the enclosed CMPA fee schedule. **If selecting type of work (TOW) code 12, 13 or 14 you must complete Section B (questions for trainees and clinical fellows).** If selecting code 14 you must provide your licence number for moonlighting work. Applicants who moonlight do not qualify for code 12 or 13. If selecting either code 20, 31 or 32, you must complete the respective questionnaire*.

Before applying for CMPA membership in type of work code 12 or 13, you may want to verify if you require CMPA protection. In some provinces/territories some degree of protection for residents can be obtained through the hospital insurer.

You must indicate all the type of work codes that most accurately describe your professional responsibilities. If you will do more than one type of work, you must pay for the type of work code with the highest risk. If you work in more than one fee region, you must pay for the region with the highest fee. Please list all provinces/territories where you work and the type of work codes that best describe the work you will do in each province/territory. Specify period(s):

Province(s)/territory(ies)	Type of work code	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)

Please describe the work you will do: _____

3 Graduate in medicine of (university, city, country) _____

 Date of graduation (mm/dd/yyyy) _____

4 If appropriate, indicate Canadian certification/qualification(s), effective date and state specialty:
 CCFP **CSPQ** **FRCP** **FRSC** **Other**, please specify _____
 Effective date (mm/dd/yyyy) _____ Specialty _____

 Non-Canadian certification/qualification(s) and specialty _____ Country _____

5 Licence/Registration information:
You must be duly licensed/registered in accordance with provincial/territorial medical regulatory (licensing) authorities to be eligible for membership.
 I am (will be) registered with a medical regulatory (licensing) authority(ies) with a:
 Full licence **Educational licence** **Training card**
 Restrictive licence (state reason why not fully licensed) _____
 Unknown at this time. When you have the licence number(s) and effective date(s), you must notify the CMPA for your membership to be finalized.

List your licensing information

Province(s)/territory(ies)	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Licence/Registration #

6 Is your permanent residence **outside** of Canada? Yes No

If **yes**, you must provide the following information:

a) Where will you be working in Canada? Name of employer _____

Employer's address _____
(APT/SUITE, STREET NUMBER AND NAME, NOT NAME OF BUILDING) (CITY)

(PROVINCE/TERRITORY) (POSTAL CODE) Telephone _____

b) Please indicate your mailing address and telephone number where you can be reached in Canada:

Address _____
(APT/SUITE, STREET NUMBER AND NAME, NOT NAME OF BUILDING) (CITY)

(PROVINCE/TERRITORY) (POSTAL CODE) Telephone _____

c) Please provide your permanent address and telephone number **outside** Canada:

Address _____
(APT/SUITE, STREET NUMBER AND NAME, NOT NAME OF BUILDING) (CITY)

(PROVINCE/TERRITORY) (POSTAL CODE) (COUNTRY)

Telephone _____

7 a) All applicants must list any commercial professional liability insurance or equivalent they held/hold as a practitioner and/or trainee. This includes professional liability protection provided by other organizations, e.g., hospitals. Include any period(s) during which you worked without protection.

Name of insurer or organization	Period from (month and year)	Period to (month and year)

b) If you held/hold commercial professional liability insurance in Canada, you may now have a gap in your protection. Would you like to receive an application for Retroactive Protection? Yes No

For further information, go to our website at www.cmpa-acpm.ca, go to Membership > Retroactive protection.

To be eligible for retroactive protection, your application must be received in our office within six months after becoming a CMPA member. Retroactive protection is available only for claims, legal actions or other proceedings starting after your retroactive application is accepted by the CMPA and you have made acceptable payment arrangements.

SECTION B – Applicants requesting membership in type of work code 12, 13 or 14 (trainees and clinical fellows) MUST complete all questions from this section.

By completing this section and signing this form you are giving your consent to the CMPA to confirm membership information to the postgraduate medical education offices or training hospitals upon their request to facilitate your postgraduate training registration.

TOW code 12: trainee without moonlighting

TOW code 14: trainee with moonlighting

TOW code 13: clinical fellow without moonlighting

Moonlighting: Independent practice of medicine outside your postgraduate training program (residency training program or structured fellowship program), whether remunerated or not.

Extra resident shifts are not considered moonlighting and are appropriate in TOW codes 12 and 13.

TOW code 13 is available for a maximum of 36 months. If the length of your training in TOW code 13 is more than 36 months, please provide additional information so that we may assess your eligibility in type of work code 13 (i.e. job description, contract details, etc.).

8 Are you pursuing a:

- residency program accredited/recognized by either the College of Family Physicians of Canada (CFPC), OR the Royal College of Physicians and Surgeons of Canada (RCPSC), OR a provincial/territorial medical regulatory (licensing) authority?
- clinical fellowship or are you a physician pursuing a structured program **not recognized** by the College of Family Physicians of Canada (CFPC), OR the Royal College of Physicians and Surgeons of Canada (RCPSC) OR a provincial/territorial medical regulatory (licensing) authority?

9 Is the training a structured program based at a recognized university, affiliated teaching hospital or medical faculty? **Yes** **No**

University or medical faculty name _____

Program start date _____ End date _____
(mm/dd/yyyy) (mm/dd/yyyy)

10 In which discipline is your training program? _____

Fellows: Please indicate exact title of fellowship _____

11 On the start date of your CMPA membership, what year of Canadian training will you be in?

12 In this membership year, will you practise medicine independently outside of your training program (moonlighting), whether remunerated or not? (Extra resident shifts are appropriate in TOW codes 12 and 13). **Yes** **No**

Clinical fellows who moonlight must review the fee schedule (go to the CMPA website at www.cmpa-acpm.ca, go to Membership > Membership fees) to select the appropriate practising code. Trainees who moonlight must hold a licence/registration acceptable to the regulatory authority (College) in the jurisdiction in which the moonlighting will occur, and provide their licence/registration number in Section A, question 5.

13 Are you registered in an assessment/evaluation program? **Yes** **No**

Name of the assessment/evaluation program : _____

Start date _____ End date _____
(mm/dd/yyyy) (mm/dd/yyyy)

14 Are you an international medical graduate registered in a program to obtain a licence for independent practice? **Yes** **No**

15 Are you doing research? **Yes** **No**

16 Have you taken or will you be taking a **specialty** certification exam at the end of your program? **Yes** **No**

Date _____ Discipline _____
(mm/dd/yyyy)

17 a) **Have you** taken a **subspecialty** certification exam? **Yes** **No**

Date _____ Discipline _____
(mm/dd/yyyy)

b) **Will you** be taking a **subspecialty** exam or receive **accreditation/certification** without examination at the end of your program? **Yes** **No**

Date _____ Discipline _____
(mm/dd/yyyy) (mm/dd/yyyy)

SECTION C – Must be completed by all applicants.

Provide details and outcomes for any questions to which you have answered YES, including clinical situation, date of incident and any recognized threat, if applicable. **List all matters including those already reported to the CMPA.**

a) Have you ever had threats or legal actions or other proceedings against yourself or your employees arising from your or your employees' medical work? Yes No

If yes, to which protective organization or insurer were they reported? _____

b) Has any insurer or other type of organization providing the equivalent of medical professional liability insurance declined, refused to renew, or only accepted on special terms, your professional liability protection? Yes No

c) Have you ever had hospital privileges reduced, restricted, or suspended, or has probation ever been invoked? Yes No

d) Have you ever been charged with professional misconduct or the like by a medical regulatory (licensing) authority? Yes No

e) Has your fitness to practise or medical competence ever been inquired into or investigated by a medical regulatory (licensing) authority? Yes No

f) Have you ever been suspended or erased from the register of a medical regulatory (licensing) authority? Yes No

g) Has there ever been any interruption in your licensure or registration? Yes No

h) Are you aware of any circumstances which could result in a threat, claim or legal action for malpractice, error or mistake being brought against you or one of your employees? Yes No

i) If you are reactivating, have there been any new threats or legal actions or other proceedings against yourself or your employees since you last had CMPA membership? Yes No

If yes, to which protective organization or insurer did you report? _____

I HEREBY APPLY to be enrolled as a member of the Canadian Medical Protective Association, and if elected, I agree to abide by the rules and regulations of the Association. **Unless I have notified the CMPA otherwise, I consent to the collection, use and disclosure of my Personal Information to the CMPA in accordance with the CMPA Privacy Policy.** I also certify that the type(s) of work and province(s)/territory(ies) of work I have designated above describe the professional work in which I will ordinarily be involved and that all the foregoing answers are correct. The CMPA may verify any of the information provided in this application and my signature both acknowledges and authorizes this validation activity. In accordance with section 2.04 of the CMPA Bylaw, the Association reserves the right to void membership and retain any money received from any applicant who is deemed by the Council to have given false or incomplete information in this application.

Date _____ Signature _____

(mm/dd/yyyy)

Payment information

The CMPA offers transition payment options to physicians during the first six months of their transition from a postgraduate training program to practice. This payment option does not apply to physicians in any other form of transition. Please call the CMPA at 1 800 267-6522 to determine your payment.

Will a payer group organization or another party remit fees on your behalf? Yes No

If yes, return your application to the CMPA with a payment, or Pre-authorized Debit (PAD) Agreement from another party/organization or a letter from your payer group.

Payment method (please choose only one):

Annual Pre-Authorized Debit (PAD):

The CMPA will debit your bank account for the full amount of your fee on the 20th day of your first month of membership. Each year thereafter, the CMPA will debit on January 20th for members on the calendar cycle; or July 20th for members on the academic cycle (or the next business day).

Monthly Pre-Authorized Debit (PAD):

The CMPA will debit your bank account on the 20th of each month (or the next business day).

Cheque

Enclose a cheque payable in Canadian funds to the CMPA for the full amount of your fee. The cheque must be dated no later than your requested start date of membership. Future fees will be payable in full on January 1st of each year for members on the calendar cycle (Jan.-Dec.) or on July 1st of each year for members on the academic cycle (July – June).

If you would like to participate in the PAD plan, you must complete the PAD Agreement below.

Pre-Authorized Debit (PAD) Agreement

I authorize the Canadian Medical Protective Association (CMPA) to debit my bank account on the date(s) indicated above, or the next business day, for all payments due to the CMPA. If a debit to my account is not honoured or if I request a change in my protection that results in a higher fee, I authorize the CMPA to debit my account the following month for the outstanding balance.

I have attached a VOID cheque from the account to be debited. (Canadian chequing or savings account only — cannot be a line of credit or credit card account.)

I understand that my participation in the PAD plan will continue until I instruct otherwise.

You have certain recourse rights if any debit does not comply with this agreement. You may revoke your authorization at any time, subject to providing notice of 30 days. For more information contact your financial institution or visit www.cdnpay.ca.

For any account where more than one signature is required, the minimum number of authorized signatories must sign and indicate their title.

Signature _____

Signature _____

Title _____

Title _____

Date (mm/dd/yyyy) _____

Date (mm/dd/yyyy) _____

Please sign this form and attach a VOID cheque.

