



QUESTIONNAIRE FOR TRAINEES AND CLINICAL FELLOWS

type of work (TOW) code 12, 13 or 14

Complete this questionnaire if you are:

- A member moving to TOW code 12, 13 or 14
- A trainee in TOW code 12 or 14 in your eighth year or more of training
- A clinical fellow in TOW code 13 in your fourth year or more of training

Name _____ Member number

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(LAST NAME) (FIRST NAME) (if applicable)

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

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

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

Fax _____ E-mail address _____

What TOW code are you requesting?

- 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 we may assess your eligibility in type of work code 13 (i.e., job description, contract details, etc.).

1 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 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 authority.

2 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)

3 In which discipline is your training program? Fellows: Please indicate exact title of fellowship.

4 Which year of Canadian training are you starting? _____

5 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**

Trainees who moonlight must hold a licence/registration acceptable to the regulatory authority (College) in the jurisdiction in which the moonlighting will occur.

Clinical fellows who moonlight must review the Fee schedule (go to the CMPA website at www.cmpa-acpm.ca, click on Membership>Membership fees) to select the appropriate practising code.

6 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)

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

8 Are you doing research? Yes No

9 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)

10 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)

11 List your current certification/qualification(s) and date(s) obtained:
 Certification/qualification _____ Date _____ Country _____
(mm/dd/yyyy)
 Certification/qualification _____ Date _____ Country _____
(mm/dd/yyyy)

12 Provide your licence/registration information:
You must be duly licensed/registered in accordance with provincial/territorial medical regulatory (licensing) authorities to be eligible for assistance.

	You are (will be) registered in the province/territory of	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Registration/licence #	Type of licence (Full licence, educational licence, training card, restrictive licence)
Province/territory of training					
Province(s)/territory(ies) where moonlighting					

IMPORTANT: By completing 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. The CMPA may verify any of the information provided in this questionnaire and your signature both acknowledges and authorizes this validation activity.

Date _____ Signature _____
(mm/dd/yyyy)