CMPA.
Empowering
better healthcare

MEMBERSHIP APPLICATION/REACTIVATION

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

Please return your completed application/reactivation form by fax, mail or member portal (requires member number and password). To avoid duplication and processing delays choose only one submission method.

All applicants must complete Sections A and C.

Were you previously a CMPA member? Yes ☐ No ☐

PLEASE PRINT

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

Your CMPA member number if applicable: _____

Mailing address: _____
(APT/SUITE, STREET NUMBER AND STREET NAME)

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

Telephone: _____
(HOME) (BUSINESS) (EXT.) (CELL)

Fax: **Email address:** _____

Gender: M ☐ F ☐ **Date of birth:** _____
(MM/DD/YYYY)

Preferred language of correspondence: English☐ French ☐

MINC Number: _____

YOUR CMPA MEMBERSHIP AND MUTUALITY

The CMPA provides liability protection for its members who, in turn, are expected to practise in a manner that aligns with the ethics and expectations of the profession and the values of the Association (the mutual) as described in its Bylaw.

THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION
P.O. Box 8225, Station T, Ottawa ON K1G 3H7 | Telephone: 613-725-2000, 1-800-267-6522 | Fax: 613-725-1300, 1-877-763-1300
www.cmpa-acpm.ca

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. A copy of the CMPA Privacy Policy can be found on the CMPA's website at https://www.cmpa-acpm.ca/en/site-resources/privacy

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 2 months.

2. Province of work and type of work:
The CMPA determines membership fees based on your type of work AND on the province or territory where you work or train (refer to the CMPA fee schedule: https://www.cmpa-acpm.ca/en/membership/fees-and-payment). **If selecting type of work (TOW) code 12 or 14 you must complete Section B (questions for residents and fellows).** If selecting code 14 you must provide your licence number for independent practice. Applicants who moonlight do not qualify for code 12.

Before applying for CMPA membership in type of work code 12, you may want to verify if you require CMPA protection. To do so, please contact your post graduate medical office or employer.

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

a. Province/territory: _____ Type of work (TOW) code(s): _____

Start date: _____ (MM/DD/YYYY) End date: _____ (MM/DD/YYYY) No end date: ☐

b. Province/territory: _____ Type of work (TOW) code(s): _____

Start date: _____ (MM/DD/YYYY) End date: _____ (MM/DD/YYYY) No end date: ☐

c. Province/territory: _____ Type of work (TOW) code(s): _____

Start date: _____ (MM/DD/YYYY) End date: _____ (MM/DD/YYYY) No end date: ☐

Please describe the work you will do:

_____

_____

_____

_____

_____

_____

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3. Graduate in medicine of : _____
UNIVERSITY CITY COUNTRY

Date of graduation: _____
(MM/DD/YYYY)

4. If appropriate, indicate Canadian certification or qualification(s), effective date and state specialty:

CCFP ☐ CSPQ ☐ FRCPC ☐ FRCSC ☐

Other, please specify:☐ _____

Effective date: _____ Specialty: _____
(MM/DD/YYYY)

Non-Canadian certification or qualification(s) and specialty: _____

Country: _____

5. Licence or registration information:

You must be duly licensed or registered in accordance with provincial or territorial medical regulatory authorities (College) to be eligible for membership.

I am (will be) registered with a medical regulatory authority(ies) (College) with a:

Full licence ☐ **Educational licence** ☐ **Training card** ☐

☐ **Restrictive licence** (state reason why not fully licensed): _____

☐ **Unknown at this time.** You may submit your membership application now without your licence or registration number(s). However, you must notify the CMPA once the licence number(s) and effective date(s) become available in order to complete the application and obtain your CMPA membership number.

List your licensing information

a. Province/territory: _____ Licence or Registration number: _____

Start date: _____ End date: _____
(MM/DD/YYYY) (MM/DD/YYYY)

b. Province/territory: _____ Licence or Registration number: _____

Start date: _____ End date: _____
(MM/DD/YYYY) (MM/DD/YYYY)

c. Province/territory: _____ Licence or Registration number: _____

Start date: _____ End date: _____
(MM/DD/YYYY) (MM/DD/YYYY)

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 STREET NAME) (CITY)

_____
(TELEPHONE) (PROVINCE/TERRITORY) (POSTAL CODE)

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

Address: _____
(APT/SUITE, STREET NUMBER AND STREET NAME) (CITY)

_____
(TELEPHONE) (PROVINCE/TERRITORY) (POSTAL CODE)

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

Address: _____
(APT/SUITE, STREET NUMBER AND STREET NAME) (CITY)

_____
(TELEPHONE) (PROVINCE/STATE) (COUNTRY) (POSTAL CODE)

7. a) All applicants must list any commercial professional liability protection or equivalent they held or hold as a practitioner or resident. This includes professional liability protection provided by the CMPA and/or other organizations, e.g. hospitals.

Include any period(s) during which you worked without protection.

i. Name of insurer or organization: _____ Licence or Registration number: _____

Period from: _____ Period to: _____
(MM/DD/YYYY) (MM/DD/YYYY)

ii. Name of insurer or organization: _____ Licence or Registration number: _____

Period from: _____ Period to: _____
(MM/DD/YYYY) (MM/DD/YYYY)

iii. Name of insurer or organization: _____ Licence or Registration number: _____

Period from: _____ Period to: _____
(MM/DD/YYYY) (MM/DD/YYYY)

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SECTION B—Complete this section if you are a resident registered in a postgraduate medical education program; a fellow or physician pursuing a structured university affiliated program; or an international medical graduate registered in a program to obtain a licence for independent practice.

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

TOW code 12: Residents and fellows without moonlighting*- includes electives anywhere in Canada
TOW code 14: Residents and fellows with moonlighting/restricted registration*-includes electives anywhere in Canada

*Moonlighting: Extracurricular (outside of a residency training program or fellowship program) practice of medicine by residents and fellows registered in a full-time postgraduate medical education program.

8. Are you:

- ☐ a **resident** registered in a postgraduate medical education program leading to certification with the College of Family Physicians of Canada (CFPC), the Royal college of Physicians and Surgeons of Canada (RCPSE), or a provincial or territorial medical regulatory authority (College)?
- ☐ a **fellow** or **physician** pursuing a structured university affiliated program?
- ☐ an **international medical graduate** registed in a program to obtain a licence for independent practice?

9. Please indicate the following:

a) The university, medical faculty, or regulatory authority (College) name: _____

b) The discipline in which you will be training: _____

c) The exact title of your training or assessment program: _____

d) Start date: _____ (MM/DD/YYYY) End date: _____ (MM/DD/YYYY)

e) The year of Canadian training you will be entering: _____

10. Please complete the following if you are an international medical graduate enrolled in an assessment program.

a) Are you registered in an assessment program to obtain a licence to practice independently? **Yes** ☐ **No** ☐

b) Will you see patients independently? **Yes** ☐ **No** ☐

c) Will you be billing independently? **Yes** ☐ **No** ☐

11. 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 code 12). **Yes** ☐ **No** ☐

Residents and fellows who moonlight must hold a licence or registration acceptable to the regulatory authority (College) in the jurisdiction in which the moonlighting will occur.

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

Date: _____ Discipline: _____ Country: _____
(MM/DD/YYYY)

13. Have you taken or will you be taking a ***subspecialty*** certification exam? **Yes** ☐ **No** ☐

Date: _____ Discipline: _____ Country: _____
(MM/DD/YYYY)

14. List your current certification(s) or qualification(s) and date(s) obtained:

Certification or qualification: _____ Date: _____ Country: _____
(MM/DD/YYYY)

Certification or qualification: _____ Date: _____ Country: _____
(MM/DD/YYYY)

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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 you 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 protection 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 authority (College)? **Yes** ☐ **No** ☐

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

f) Have you ever been suspended or erased from the register of a medical regulatory authority (College)? **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, legal action, or other proceeding for malpractice, error, or mistake being brought against you or one of your employees? **Yes** ☐ **No** ☐

i) If you are reactivating your membership, have there been any new threats or legal actions, or other proceedings against you 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 (CMPA), and if elected, I agree to abide by the rules and regulations of the CMPA. I agree to advise the CMPA as soon as practicable if and when my contact information changes. I understand that the CMPA retains discretion as to whether it will grant assistance in any matter or proceeding brought against me, pursuant to its bylaw.

In further protection of my interests and in the sole event that I cannot be located or reached after reasonable attempts by the CMPA to contact me, I hereby designate the Director of Physician Consulting Services of the CMPA to act from time to time as my attorney for the purposes of requesting assistance from the CMPA if a civil action is brought against me, and if a decision is made to grant assistance in these circumstances, my said attorney shall then leave such matter unreservedly in the hands of the CMPA and its counsel to act according to their decision as to the conduct, defence or, settlement of the case.

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) or 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 CMPA Council to have given false or incomplete information in this application.

Signature: Date: (MM/DD/YYYY)

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Payment information

Payment method (please choose only one):

☐ **Annual pre-authorized debit (PAD)**

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

Upon receiving your application, the CMPA will contact you to provide you with further payment instructions. Should you have any questions, please send an email to inquiries@cmpa.org.

All payments (including international) must be in Canadian funds and drawn on a Canadian bank.

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 below, or the next business day, for all payments due to the CMPA as detailed on my invoice. 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 hereby waive my right to receive pre-notification of the amount of the PAD and agree that I do not require advance notice of the amount before the debit for my personal PAD is processed.

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. I may revoke my authorization at any time, subject to providing notice of 30 days.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for a PAD that is not authorized or is not consistent with the term of this agreement. To obtain more information on my recourse right, I may contact my 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: _____ Date: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Please sign this form and attach a VOID cheque.

END

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