

POSTGRADUATE QUESTIONNAIRE

Type of work (TOW) code 12 or 14

Complete this questionnaire if you are:

- a member moving to TOW code 12 or 14
- a resident registered in a postgraduate medical education program
- a clinical fellow or physician pursuing a structured university affiliated program
- an international medical graduate registered in a program to obtain a licence for independent practice

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:

What TOW code are you requesting?

- TOW code 12** Residents and fellows without moonlighting*
- TOW code 14** Residents with moonlighting/restricted registration*

**Moonlighting: Extracurricular (outside of a residency training program) practice of medicine by residents 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 (RCPSC), or a provincial or territorial medical regulatory authority (College).*

YOUR CMPA MEMBERSHIP AND MUTUALITY

CMPA membership is based on the principles of mutuality. The CMPA provides members—residents, clinical fellows, and practising physicians—with liability protection, advice, and resources to help manage medical-legal risk in clinical practice. In turn, members 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.

1. 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 (RCPSC), or a provincial or territorial medical regulatory authority (College)?
- a **clinical fellow** or **physician** pursuing a structured university affiliated program?
- an **international medical graduate** registered in a program to obtain a licence for independent practice?

2. 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: _____ End date: _____
(MM/DD/YYYY) (MM/DD/YYYY)
- e) The year of Canadian training you will be entering: _____

3. 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.

Clinical fellows who moonlight must review the fee schedule (go to the CMPA website at www.cmpa-acpm.ca) to add appropriate practising code(s) to their membership profile.

4. Have you taken or will you be taking a **specialty** certification exam at the end of your program?

Yes No

5. Have you taken or will you be taking a **subspecialty** certification exam?

Yes No

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

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

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

7. Provide your licence or registration information:

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

Province or territory of training:

You are (will be) registered in the province or territory of: _____

Licence or Registration #: _____ From: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Type of licence: Full licence Educational licence Training card Restrictive licence Other: _____

Province or territory(ies) where moonlighting:

a. You are (will be) registered in the province or territory of: _____

Licence or Registration #: _____ From: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Type of licence: Full licence Educational licence Training card Restrictive licence Other: _____

b. You are (will be) registered in the province or territory of: _____

Licence or Registration #: _____ From: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Type of licence: Full licence Educational licence Training card Restrictive licence Other: _____

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.

Signature: _____ Date: _____
(MM/DD/YYYY)

Please return the completed form to the CMPA by fax, mail or member portal (requires member number and password) as shown at the bottom of this form.