Ontario Ministry of Health

# Application to Re-enter Postgraduate Medical Training

Fields marked with an asterisk (*) are mandatory.

## Section 1 – Applicant Personal Information

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

**Permanent Address**

| Unit Number | Street Number | Street Name | Rural Route | PO Box |
|---|---|---|---|---|
| | | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

**Mailing Address (if different)**

| Unit Number | Street Number | Street Name | Rural Route | PO Box |
|---|---|---|---|---|
| | | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | | |

| Telephone Number (daytime) | Telephone Number (evening) | Email Address * |
|---|---|---|
| | | |

Are you a Canadian Citizen or Permanent Resident? ☐Yes ☐No

**You are not eligible for the program**

## Section 2 – Applicant Medical Practice and Education History

### Medical Practice History

Are you a family physician or general practitioner? ☐Yes ☐No

Do you have a current Canadian Certification in Family Practice (CCFP) from the College of Family Physicians of Canada? ☐Yes ☐No

Are you a specialist? ☐Yes ☐No

Specify specialty

Do you have a current specialty certification with the Royal College of Physicians and Surgeons of Canada (RCPSC)? ☐Yes ☐No

Specify specialty

Are you currently enrolled in a Re-Entry specialty training in PGY 3 level or higher? ☐Yes ☐No

Name of Program

| Name of University | Level of Training |
|---|---|
| | |

Are you legally entitled to work in Canada? ☐Yes ☐No

If accepted into postgraduate program, would you be able to provide proof of your legal status? ☐Yes ☐No

Do you have any undischarged return of service commitment in Canada? ☐Yes ☐No

Specify

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Are you eligible for registration with the College of Physicians and Surgeons of Ontario? ☐Yes ☐No

**You are not eligible for the program**

Currently licensed to practice in (Do not include Educational License)

| Province/State | Country | Year | Number |
|---|---|---|---|
| | | | |

## Education History

### Pre-medical Education

| University/College Attended | Date From (yyyy/mm/dd) | Date To (yyyy/mm/dd) | Year Graduated | Degree Obtained | Major Field of Study |
|---|---|---|---|---|---|
| | | | | | |

### Medical Education

| Medical School | City | Country | Degree | Year Granted |
|---|---|---|---|---|
| | | | | |

Have you ever previously been enrolled at an Ontario Medical School? ☐Yes ☐No

| Name of School | Student Number |
|---|---|
| | |

### Postgraduate Medical Education (internship, residencies, etc.)

| Hospital/University | City | Date From (yyyy/mm/dd) | Date To (yyyy/mm/dd) | Position Held |
|---|---|---|---|---|
| | | | | |

Have you ever withdrawn or been required to withdraw from any postgraduate medical training program? ☐Yes ☐No

Specify when and provide reasons

Have you ever been disciplined by a University or medical licensing authority? ☐Yes ☐No

Specify when and provide reasons

Have you ever had your medical licence or certificate of registration revoked in any jurisdiction? ☐Yes ☐No

Specify when and provide reasons

Have you ever had your hospital privileges revoked in any jurisdiction? ☐Yes ☐No

Specify when and provide reasons

Has your training been assessed by either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada? ☐ Yes ☐ No

Specify when and append a copy of this assessment in Section 3 Supporting Attachments

**Professional Positions Held**

| Organizations | City | Date From (yyyy/mm/dd) | Date To (yyyy/mm/dd) | Position Held |
|---|---|---|---|---|
| | | | | |

## Section 3 – Supporting Attachments

| File Name | Size (MB) | Selected File |
|---|---|---|
| | | ☐ |
| **Total** | | |

## Section 4 – Selection of Programs and Location of Training

- List the specialty of interest (maximum 3) below;
- Check the program stream that your specialty of interest relates to;
- Check the location at which you would like to be considered for each specialty. The Ministry may forward your completed package and letter to the medical school(s) that you have identified below upon request. You may check more than one medical school for each specialty provided the school offers training in that specialty.

| Specialty of Interest (type of program) | Program stream | | | | | Tra | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2 yrs Family Medicine (FM) | FM-Specialty (PGY3) | General Specialty | Sub-Specialty | PHPM | Toronto | McMaster | Western | Queen's | Ottawa | Northern ON School of Medicine | Toronto Metropolitan |
| Example: Internal Medicine | | | ✔ | | | ✔ | ✔ | ✔ | | | | |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Consents and Declarations of Applicant

I certify that the information recorded herein is complete and accurate. Any falsified documentation or evidence provided to the Ministry at any time, including after the Return-of-Service Agreement comes into force, may be the basis for dismissal from the program or termination of the agreement. I hereby grant my permission to contact, for further reference any person/institution cited in this application or appendices.

## Notice of Collection, Use and Disclosure of Personal Information

The personal information that the Ministry of Health collects in this application is necessary for the proper administration of the Re-Entry Program. It will be used to verify your eligibility for the Re-Entry Program, process your application and to administer the Return of Service (ROS) commitment of the program. This information may be disclosed to the members of the Re-Entry Working Group, as well as Program Directors and Postgraduate Medical Education Offices at the medical schools to which you have applied.

The Ministry of Health requires your Certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario (CPSO) or from the medical regulatory authority of any province or territory in Canada in which you are licensed to practise medicine. In addition, in the event that you do not fulfill your return of service requirements, the Ministry may contact the medical school you attended for your Re-Entry Program training position, to obtain financial information about your salary and benefits in order to calculate the repayment amount. By signing this consent form, you authorize the Ministry to directly collect this information from the CPSO, medical regulatory authority of any province or territory in Canada and your medical school.

The Re-Entry Program is administered under the authority of the *Ministry of Health and Long-Term Care Act*, clause 6(2)(b).
If you have any questions about this collection and disclosure of information, please contact the Ministry's Program Officer, Ministry of Health, Capacity and Health Workforce Planning, Health Workforce Planning and Programs Unit, telephone: 416-327-8339, or email ReEntry@Ontario.ca.

| | |
|---|---|
| ☐ **I have read and understood this section, including notice of collection, use, and disclosure of my personal information. By selecting this box to represent my e-signature, I am attesting to my consent to the indirect collection, use, and disclosure of my personal information and that my declaration is complete and true.** * | Date (yyyy/mm/dd) |