Ontario

Ministry of Health
Emergency Health Regulatory
and Accountability Branch

Paramedic Labour Mobility Application

The Emergency Health Regulatory and Accountability Branch (EHRAB) is authorized to collect personal information contained on this form by virtue of it being necessary for proper administration of a lawfully authorized activity, that is, to determine the applicant's eligibility to proceed with the Ministry of Health (MOH) Paramedic Labour Mobility Equivalency Process. Paramedic equivalency is authorized under Part III of Ontario Regulation 257/00 made under the *Ambulance Act*. For information concerning this process contact: Manager, Certification and Patient Care Standards, (EHRAB), MOH, 5700 Yonge Street, 6th Floor Toronto ON M2M 4K5 Telephone: 416-327-7900.

- **It is the candidate's responsibility to read and comply with the accompanying Information and Application Package document regarding Paramedic Labour Mobility Equivalency.**
- **Please print clearly and in ink. Fields marked with an asterisk (*) are mandatory.**

Applicant Information

Last Name *	First Name *	Middle Name

Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Telephone Number *	Alternate Telephone Number	Email *

Licensure/Registration Status

Province/territory currently licensed/registered *	Level of Practice *
	☐PCP ☐ACP

Requirements

☐ Certified cheque or money order in Canadian funds payable to the Minister of Finance in the amount of $100.00.* **Cash or personal cheques will not be accepted. ***

☐ Originally signed Verification of Licensure/Registration Form received from all Regulators (current and previous) *

Completed application and fee must be mailed to:

Ministry of Health
Emergency Health Regulatory and Accountability Branch
Certification and Patient Care Standards
5700 Yonge Street, 6th Floor
Toronto ON M2M 4K5

Signature

A. This is to certify that I have read the Information and Application Package document and agree to comply with the policies as described.

B. This is to certify that the information on the form is true, correct and complete to the best of my knowledge.

C. I hereby permit Emergency Health Regulatory and Accountability Branch, Ministry of Health and other paramedic regulators to exchange information pertaining to my application for paramedic equivalency. The information will be kept confidential and is for internal use only to determine eligibility for paramedic equivalency.

Signature *	Date (dd/mm/yyyy) *

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For the purposes of this form:

Registration is in reference to the status of an individual as Registered (or equivalent), such that he/she has successfully completed a Canadian paramedic Regulator's entry to practice examination, and may be certified, subject to meeting the requirements of that regulatory authority.

Certification is in reference to the status of an individual as Certified (or equivalent), such that he/she holds a license, practice permit, or equivalent, issued by a Canadian paramedic Regulator that attests to the individual being authorized to practice.

Section A – Applicant Section

This section of the form is to be completed by the Applicant. The information provided below should only pertain to the Level of Registration/Certification to be verified. This form must be completed by every jurisdiction in which the requestor is Registered or has been Registered.

Last Name	First and Middle Name
Former/Previous Name(s)	Address (including country)
Other certifying bodies under which registration or certification is or has been issued	Practice Level ☐EMR ☐PCP ☐ACP ☐CCP
Email	Telephone

☐I certify that the information on this form is true, correct and complete to the best of my knowledge.

☐I authorize the collection, use and disclosure any information regarding my paramedic practice for the purpose of the verifying my status as a paramedic. I acknowledge that I have been notified about the verification process, including that information about me may be collected, used and disclosed, the purposes for which the information collected may be collected, used and disclosed, the fact that third parties may have access to that information, the fact that such information may be transferred outside of province of practice to other jurisdictions that may have different laws protecting personal information or data, and the process by which I may access the data collected about me for the purpose of correction or deletion of erroneous data. By submitting my information and signing below, I knowingly and voluntarily consent to the collection, use, disclosure and verification of information regarding my status, practice and certification as a paramedic, including but not limited to education, qualifications and employment history, and for those organizations to collect, use, disclose and verify such information. I understand and acknowledge that the information collected is required to verify and confirm my practice and good standing as a paramedic with any paramedic regulatory authority under which I currently practice, for the purposes of seeking employment opportunities in another jurisdiction.

Signature	Date (dd/mm/yyyy)

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Section B – Regulator Section

This section of the form is to be completed by the Regulator. Incomplete forms will be returned to the Applicant. The information provided below should pertain to the Level of Registration/Certification indicated by the Applicant above. This form must be completed by every jurisdiction in which the requestor is Registered or has been Registered.

Regulator	Name of Applicant

Practice Level	Registration Number	Registration obtained by
☐EMR ☐PCP ☐ACP ☐CCP	Registration Date (dd/mm/yyyy)	☐Examination ☐Previous Registration ☐Labour Mobility ☐Other, specify:

Is this Applicant currently Certified (if certification is temporary or provisional, please provide details in Additional Comments)?

☐Yes Certification Expiration Date: (dd/mm/yyyy)

☐No If No:

What was the last Certification Expiration Date (dd/mm/yyyy)?

Was this Applicant a student in the previous year? ☐Yes ☐No

Has the Applicant's Registration or Certification been denied, revoked, restricted, suspended, or under review at any time?

☐Yes (please provide details, including reinstatement status/date or conditions, if applicable, in Additional Comments)

☐No

Additional Comments

Contact Name	Contact Title
Contact Telephone	**Contact Email**

Signature	Date (dd/mm/yyyy)

Completed forms are to be sent to: Ministry of Health, Certification and Patient Care Standards, 5700 Yonge Street, 6th Floor Toronto ON M2M 4K5 or CertificationExams@ontario.ca