Ontario

Ministry of Health

Pregnancy and Parental Leave Benefits Program (for Physicians)

☐ Full Application Package

☐ Part 2 – Income Confirmation (only)

☐ Part 3 – Declaration of Earned Income (only)

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Ontario Ministry of Health

Pregnancy and Parental Leave Benefits Program (for Physicians) Part 1 – Application

Fields marked with an asterisk (*) are mandatory.

PPLBP Application Checklist

☐Part 1 - Application form

☐Part 2 – Income Confirmation form (if applicable, for non-fee for service income sources)

☐Part 3 – Declaration of Earned Income form (submitted monthly)

☐Copy of child's birth registration, adoption placement letter or stillbirth certificate

Application Submission Deadline

The complete, signed application and all supporting documents must be received within 12-months of the child joining the parent. Incomplete and/or unsigned supporting documents received after this deadline will not be processed, and no benefits will be issued.

Applications and any supporting documents must be submitted in PDF or JPEG format to pplbp@ontario.ca

PPLBP will confirm receipt of the application via email within 15 business days of the submission date. If no email is received within this time period, please follow up with the program.

Note: It is the physician applicant's responsibility to ensure that they understand the program policies and that their application is submitted on time, whether they are submitting it themselves or through a third-party.

Questions? Email pplbp@ontario.ca

1.1 Physician Information

Last Name (Dr) *	First Name *

CPSO License Number *	OHIP Billing Number *	Email Address *

Home Mailing Address

Apt/Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province * ON	Postal Code *

Telephone Number *

Primary Practice Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province * ON	Postal Code *

Application Type (select one) *

☐Pregnancy Leave (Birth mothers only)	Start Date (yyyy/mm/dd) *
☐Parental Leave (Fathers or non-birth mothers)	Start Date (yyyy/mm/dd) *
☐Parental Leave (Adoption)	Start Date (yyyy/mm/dd) *
☐Parental Leave (Surrogacy)	Start Date (yyyy/mm/dd) *
☐Stillbirth (Birth mothers only)	Start Date (yyyy/mm/dd) *

Birth Mothers: If not taking the full 22 weeks, please declare the number of weeks you are applying for in total: *

All other Parents: If not taking the full 17 weeks, please declare the number of weeks you are applying for in total: *

Leave will be taken in *

☐Consecutive weeks ☐Non-Consecutive weeks

As a reminder, non-consecutive leave must be taken as a minimum of two-week increments and the weeks must be in 7-day increments from Sunday to Saturday. Please declare the weeks of leave taken and income earnings for those weeks of leave on Part 3 – Declaration of Earned Income form (page 5).

Expected Birth Date (yyyy/mm/dd) * (Birth mothers only, if starting leave before expected date of delivery)

Actual Birth Date (yyyy/mm/dd)

Actual Adoption Placement Date (yyyy/mm/dd)

Are you primarily an ER/ICU/CCU physician? * ☐Yes ☐No

Are you a signatory physician with a roster in a primary care model? *

☐Yes ☐No If Yes, specify which model (CCM, FHG, FHN, FHO, FHT, GHC)

1.2 Eligibility

1. Were you licensed to practice medicine in Ontario during the full 12 months immediately before the start of your Pregnancy or Parental Leave?

   ☐Yes ☐No

   If No, provide the dates you were licensed to practice in Ontario otherwise go to question 3:

   From (yyyy/mm/dd) To (yyyy/mm/dd)

2. Did you complete a Residency program in Ontario in the 12 months immediately before the start of your Pregnancy or Parental Leave?

   ☐Yes ☐No

   If Yes, provide the Residency PGYr(s) and dates during the 12 months immediately before leave start date.

   PGYr From (yyyy/mm/dd) To (yyyy/mm/dd)

   PGYr From (yyyy/mm/dd) To (yyyy/mm/dd)

3. Have/will you receive maternity, pregnancy and/or parental leave benefits from the EI Program at any time during your leave (before, during or after PPLBP benefits)?

   ☐Yes ☐No

4. Have/will you receive maternity, pregnancy and/or parental leave benefits from your workplace, employer or partnership at any time during your leave (before, during or after PPLBP benefits)?

   ☐Yes ☐No

1.3 Pre-Leave Income Statement

List your gross income from all OHIP insured clinical services provided in Ontario during the 12-month period prior to the start of your leave. Physicians participating in APP, AFA, AHSC-AFP, Salaried Physicians and Physicians receiving "other medical professional income" must submit **Part 2 - Income Confirmation** (page 4) to verify their earnings. One form is required for each non-fee for service source of income.

Fee for Service Income: Direct billings excluding technical fees	$
Primary Care Model Physicians: All payments received through primary care agreements, i.e. billings, base rate and comprehensive care capitation payments, bonuses, premiums, and other incentives	$
Specialists: All payments of any kind received under any APP, AFA, or AHSC AFP	$
Salaried Physicians: Income from an employer for OHIP-insured clinical services	$
Residents: PARO Salary Earnings	$

All Physicians: Please list below other medical professional income including locum payments, sessional payments, stipends or supplements received from a Hospital, Community Agency/Organization, LHIN, Long-Term Care Facility, Ministry and/or Government Agency.

	$
	$
	$
Total	$

1.4 Consent

1.4.1 The Ministry of Health (the Ministry) is authorized to collect and use the personal and financial information requested in Parts 1, 2, 3 and 4 of this package for administering the Pregnancy and Parental Leave Benefit Program (the Program) under s.4.1 (1) of the *Health Insurance Act*, R.S.O. 1990, c.H.6, s. 39 of the *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.36, s.6 (1) of the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c.M.26 and s36 (1) (a) of the *Personal Health Information Protection Act, 2004*. The personal information so collected is used to administer the Program, generate statistical information pertaining to it, report on it, evaluate it and support related research.

1.4.2 The information contained in electronic correspondence with the Ministry of Health is intended for the person(s) or entity to whom it is addressed. Delivery of any message to any person other than the intended recipient(s) is not intended in any way to waive confidentiality. The program related material may contain confidential or personal information which may be subject to the provisions of *Ontario's Personal Health Information Protection Act*. Any review, retransmission, dissemination or other use of the information by entities other than the intended recipient is prohibited.

1.4.3 I understand that if I receive more money from the Program than the amount to which I am entitled for that week, the Ministry may deduct an amount equal to the excess from any future benefits paid to me under the Program. If the Ministry is unable to recover the whole of the excess by deduction from future payments under the Program, the Ministry may recover the balance of the excess by any lawful means including, but not limited to, deduction from any amounts otherwise payable to me by OHIP or under an AFA.

1.4.4 I declare that I have read and understood the Program Guidelines, Application Package and Answers to Frequently Asked Questions, available at http://www.health.gov.on.ca/en/pro/programs/parentalleave/ and agree to abide by the terms and conditions therein.

I certify that the information provided in this application package is true and accurate.

	Date (yyyy/mm/dd)

Ontario

Ministry of Health

Pregnancy and Parental Leave Benefits Program (for Physicians) Part 2 – Income Confirmation

One form is required to verify each non-fee for service income source. If you have multiple sources of income from one employer/organization, it can be combined on to one form (i.e. locum earnings for multiple physicians at one location).

This form is not required for direct Fee for Service billings, Physician Enrollment Model earnings or PARO salary earnings from a residency program.

2.1 Physician Information (to be completed by the physician applying for benefits)

Last Name (Dr) *	First Name *	
CPSO License Number *	OHIP Billing Number *	Leave Start Date[1] (yyyy/mm/dd) *

[1] **The start date of your leave must be the same in Parts 1 and 2 of this application.**

I grant consent to the Administrator of my AFA/Employer/Representative from my Paying Agency to disclose the total amount paid to me during the 12-month period immediately preceding the start date of my pregnancy and/or parental leave, to the Pregnancy and Parental Leave Benefits Program, Ministry of Health.

I have reviewed the information in Sections 2.1, 2.2 and 2.3 and certify that it is true and accurate.

	Date (yyyy/mm/dd)

2.2 AFA, Employer, Physician Lead or Paying Agency Information (to be completed by the AFA Administrator/Employer/Paying Agency Representative)

Please check one: ☐AFA ☐Employer ☐Other (Specify) ▶

Name of AFA, Employer or Paying Agency

Name of the Administrator / Representative

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code
	ON	

Telephone Number	Fax Number	Email Address

2.3 Income Information (To be completed by AFA Administrator or similar staff member)

Declare below the gross income earned by this physician for providing OHIP insured clinical services during the 12-month period immediately before the leave start date shown in Section 2.1 above. **Example: Start date April 3, 2025 = income confirmed between April 3, 2024 to April 2, 2025.**

Gross Eligible Income	From (yyyy/mm/dd)	To (yyyy/mm/dd)

Will this physician receive payments through your organization, at any time during their leave (before, during or after PPLBP benefits) for being on pregnancy/maternity and/or parental?

☐No ☐Yes (Provide details) ▶

Benefit per week ($)	Number of Weeks	Starting Date (yyyy/mm/dd)

Will the physician receive any earnings or salary for providing insured clinical services during the weeks of their leave?

☐No ☐Yes (Provide details of income type and amounts if known)▼

I certify that the information provided in sections 2.2 and 2.3 above is true and accurate.

Signature (AFA Administrator/Employer's Representative/Paying Agency)	Date (yyyy/mm/dd)

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Pregnancy and Parental Leave Benefits Program (for Physicians) Part 3 – Declaration of Earned Income

This form must be submitted by the **28th day of every month** you are on leave to declare your weekly income earnings. If your income earnings are zero for some weeks, you must declare $0 in the "income" table below.
If you are taking consecutive leave and will be earning zero income (other than EI/Employer benefits) for the duration of your leave(s), you may indicate this in question 2 below and submit **one** completed **Part 3** form.
No payment is issued without a Part 3 form. Please complete this form and email it to pplbp@ontario.ca.

Last Name (Dr) *	First Name *
CPSO License Number *	OHIP Billing Number *

1. Will you be taking your leave in non-consecutive weeks? ☐Yes ☐No

If "yes," provide the weeks you are on leave and your income earnings in the "income" table below.

2. Are you taking a consecutive leave and declaring zero income earned for the duration of your leave? ☐Yes ☐No

3. Will you receive EI and/or Employer-provided Pregnancy/Maternity/Parental Leave Benefits at any time during your leave (before, during or after PPLBP benefits)?

☐Yes ☐No If "yes," provide the details in the "benefit" table below.

Employment Insurance (EI) Benefits for Maternity/Pregnancy/Parental Leave			**Employer-provided Benefits for Maternity/Pregnancy/Parental Leave**		
Start Date (yyyy/mm/dd)	End Date (yyyy/mm/dd)	Gross Weekly Amount	Start Date (yyyy/mm/dd)	End Date (yyyy/mm/dd)	Gross Weekly Amount

Income for all the weeks in your leave must be reported below.
Benefits are calculated from Sunday to Saturday (yyyy/mm/dd).
If you are starting your leave mid-week please ensure your Week 1 start date matches your leave start date.

	Week 1	Week 2	Week 3	Week 4	Week 5
	From	From	From	From	From
	To	To	To	To	To
Source of Income[1] Please see the instructions section on how to calculate and declare weekly income earnings. Declare one income source per line	($)	($)	($)	($)	($)
1					
2					
3					
4					
Locum Deduction (FHN, FHO, models only). This amount cannot exceed the PCM capitation amount declared above.					
Locum Coverage Payment					

This document discloses all my gross income for OHIP insured clinical services I provided during my leave and Employment Insurance (EI) and/or employer-provided benefits I am/will be receiving, in connection with this leave. I certify that the information provided here is true and accurate and that I was on leave for the week(s) noted above.

	Date (yyyy/mm/dd)