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CMPA
Empowering better healthcare

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 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*—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.*

YOUR CMPA MEMBERSHIP AND MUTUALITY

CMPA membership is based on the principles of mutuality. The CMPA provides members—residents, 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 **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: _____ (MM/DD/YYYY) End date: _____ (MM/DD/YYYY)

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

3. 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** ☐

4. In this membership year, will you practice 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.

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

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

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

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

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

8. 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: _____ (MM/DD/YYYY) To: _____ (MM/DD/YYYY)

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

Province(s) or territory(ies) where moonlighting:

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

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

END