Box 2703 (C-18)
Whitehorse, YT Y1A 2C6
Phone: 867.667.3774
Fax: 867.393.6483

REQUEST FOR CERTIFICATE OF PROFESSIONAL CONDUCT (CPC)

REQUEST

I, Dr. ____, request that a Certificate of Standing/Conduct be forwarded to:

Attention: ___________________________________

Name of Organization/Licensing Authority: ____

Address: ____

City: _______________________________ Province/State: __________________________

Postal Code/Zip: ____________________ Country: _________________________________

Telephone: ________________________ Fax: ____________________________________

AUTHORIZATION

My signature below authorizes Yukon Medical Council to release personal information whether favourable or unfavourable concerning my licensure and registration.

Physicians Name (Please Print): ____

Physician's Signature: _____________________________________ Lic. # _________________

Address: ____

City: _______________________________ Province/State: __________________________

Postal Code/Zip: ____________________ Country: _________________________________

Telephone: ________________________ Fax: ____________________________________

FEE: $5 for each CPC issued (whether original or copy)

Payment Accepted by: Cash, Cheque, VISA or MasterCard

Credit Card Number: ______________________________________ Expiry Date: ____/____

Name of Cardholder ____ Authorized Amount: ____________

Signature of Cardholder: ____________________________________ Date: ______________

I hereby authorize Yukon Medical Council to charge my credit card.

PLEASE FORWARD THE COMPLETED FORM BY:

MAIL TO: **Yukon Medical Council**
PO Box 2703
Whitehorse, Yukon
Y1A 2C6

or **FAX TO: 867-393-6483**

The information collected in this form will be used for processing your request. If you have any questions about the collection and use of this information, please contact our office at 867-667-3774.