



MEDICAL PROFESSION ACT
MEDICAL POST GRAD REGISTRATION APPLICATION

I hereby apply for registration for a temporary certificate to practice medicine under the Yukon Educational Register pursuant to section 9 of the *Medical Profession Act*, as a postgraduate physician in training.

PERSONAL INFORMATION

Name (last, first)	
Present Address	
Contact Phone Number	
Contact Email	
Date of Birth	
Name of Supervisor	
Yukon Clinic	
Dates of Yukon Rotations	

DEGREE

Title of Medical Degree	
Date Granted	
Name of School Granting Degree	
City of School Granting Degree	

MEDICAL COUNCIL OF CANADA EXAMINATIONS

	Taken	Dates Taken	Passed
Evaluating (MCCEE)	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Qualifying (MCCQE – Part 1)	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Qualifying (MCCQE – Part 2)	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Other examinations	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

LMCC #	
Date Issued	
MINC#	

Are your documents on file with PCRC? Yes No



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POSTGRADUATE TRAINING

I am in my _____ year of a _____ year program.
(if you are in the first year of your residency program, please indicate the number of months you have completed)

Residency Program is in what field? _____.

To assist with your Hospital Privileges application.

- Check if you wish our office to forward copies of your CMPA and Program Director's letter to the Yukon Hospitals, Administration Department.

AUTHORIZATION OF APPLICANT:

I hereby certify that the information provided in this application is true. If, prior to the issuance of a certificate there is any change in the information provided in this application, I will immediately inform the Council and provide details of that change.

I hereby authorize the Yukon Medical Council to make such inquiries about me as it considers appropriate in connection with this application.

In submitting this application, I declare that I am the person referred to in the application and that the information provided therein is accurate and complete. Furthermore, I declare that the person named on any forms to be submitted with the application, as well as my signature and photograph (if applicable) on those forms, are for one and the same person.

Applicant's signature

Date

ALL applications must be submitted to YMC.

Expect up to 30day processing time.

Fax: 867-393-6483 Email: ymc@gov.yk.ca	
Mail to: Yukon Medical Council Box 2703, C-18 Whitehorse, Yukon Y1A 2C6	Courier or Bring in person to: Yukon Medical Council 1 st floor - 307 Black Street Whitehorse, Yukon Y1A 2N1

DOCUMENT CHECKLIST

- An original signed letter from your Provincial Program Director detailing the dates and duration of each completed rotation, confirmation that you are a post-graduate trainee in good standing and that you are approved for the proposed rotation in the Yukon Territory.
- Proof of CMPA insurance showing Yukon coverage or code 12 or14
- A copy of the document which legally entitles you to reside in Canada (*i.e. Birth certificate, passport, student visa*)
- A recent passport type photo
- Original signed undertaking regarding the prescribing of medications
- Prescription privileges will not be granted unless this is completed
- Original signed application must be signed