YUKON MEDICAL COUNCIL

MEDICAL PROFESSION ACT
REQUEST OF CERTIFICATE OF PROFESSIONAL CONDUCT

REQUEST

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

Attention	
Name of Organization/Licensing Authority	
Address (full with postal code)	
Telephone	
Fax	

AUTHORIZATION

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

Physician Name	
Yukon License Number	
Address (full with postal code)	
Telephone	
Email	

Physician Signature _____ Date _____

www.yukonmedicalcouncil.ca
Located: 307 Black Street, Whitehorse, Yukon Y1A 2N1
Mailing: PO Box 2703, C-18, Whitehorse, Yukon Y1A 2C6

Phone: 867.667.3774
Fax: 867.393. 6483
Email: ymc@gov.yk.ca

YUKON MEDICAL COUNCIL

MEDICAL PROFESSION ACT
REQUEST OF CERTIFICATE OF PROFESSIONAL CONDUCT

CPC FEE

ALL applications must be either faxed, mailed, couriered or brought in person.
Phone and email are no longer an acceptable means of submission.

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

CPC Request fees are **$5.00**

Cheques are payable to **Government of Yukon** or

Credit Card information

Card Number _____ Expiry Date _____

Signature: _____