Attach recent, Passport type photo

Application for Medical Postgraduate Registration

MAILING ADDRESS

Yukon Medical Council
Box 2703 (C-18)
Whitehorse, Yukon
Y1A 2C6

COURIER ADDRESS

Yukon Medical Council
Berska Building
1st Floor, 307 Black Street
Whitehorse, Yukon
Y1A 2N1

Phone: (867) 667-3774 Fax: (867) 393-6483 email: ymc@gov.yk.ca

www.yukonmedicalcouncil.ca

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

Full Name ____
(last name) (given names)

Present Address ____

Contact Number ____________ Email Address ______________________

Date of Birth:__________________ Gender ☐M ☐F

Name of Supervisor in Yukon: ______________________________

Dates of Yukon Rotation: __________________________________

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 ☐ No ☐	____________	Yes ☐ No ☐
Qualifying (MCCQE – Part 1)	Yes ☐ No ☐	____________	Yes ☐ No ☐
Qualifying (MCCQU – Part 2)	Yes ☐ No ☐	____________	Yes ☐ No ☐

LMCC # ______________ Date Issued________________________________
MINC # ________________________________
Other examinations taken ____

Are your documents on file with PCRC? Yes ☐ No ☐

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? ____.

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

PLEASE INCLUDE THE FOLLOWING DOCUMENTATION WITH YOUR APPLICATION:

- 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.

- Documentation confirming liability insurance is in place for this elective. For example your CMPA document detailing Yukon and dates of your rotation.

- 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

- The attached undertaking signed regarding the prescribing of medications. Prescription privileges will not be granted unless this is completed.

- Application must be signed. The Yukon Medical Council requires receipt of the original application form to process any application for licensure. Please send the application by registered mail or express post to the address indicated on the application form. **Emailed or faxed applications will not be processed.**

- **It is your responsibility to contact the Whitehorse General Hospital to apply for hospital privileges for your elective. Please contact Kathy Milley at 1-867-393-8979 or Kathy.Milley@wgh.yk.ca.**