



## Institutional Request for Certificate of Professional Conduct

Please complete this electronic form, print out, sign, and

**Fax to: 416-967-2654 OR**

**Mail to:** College of Physicians and Surgeons of Ontario, 80 College Street, Toronto ON M5G 2E2

Date of Request

Name of Institution

Attention

Street

City  Province  Postal Code

Telephone  Email

To the Registrar of the College of Physicians and Surgeons of Ontario:

Dr.  Member's CPSO number

has applied for hospital privileges at the

## Consent for Release of Information

I, Dr.

a member of the College of Physicians and Surgeons of Ontario, certify that I have read the request for a Certificate of Professional Conduct and the definition of information to be included in that Certificate, printed on the document of which this Consent forms a part. I understand the nature of the information which will comprise the requested Certificate of Professional Conduct which is outlined on page 2 of this form and I further understand that the College will not release this information further to this request unless I consent to its release and evidence that consent by signing this Consent Form.

I hereby consent to the release of the Certificate of Professional Conduct defined in the document of which this Consent forms a part by the Registrar of the College of Physicians and Surgeons of Ontario to the:

Name of hospital or institution

and I request the registrar to do so.

This Consent shall be valid for six months from the day on which I signed it.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date of signature of Member

Member's mailing address:

Member's CPSO number

**All fields must be completed**

## Information Provided in a Certificate of Professional Conduct

1. The member's qualifications as known to the College (as recorded on the Register) including date and place of primary medical qualification.
2. The class of certificate of registration held by the member and any terms and conditions attached thereto.
3. The current address of the member as recorded on the Register.
4. The specialty qualifications of the member as recorded on the Register.
5. The history of any previous disciplinary or Fitness to Practise findings as recorded on the Register.
6. The history of any terms and conditions attached to the certificate of registration as recorded on the Register.
7. Whether the member's conduct or fitness to practise is or is not the subject of an inquiry by the Discipline Committee or Fitness to Practise Committee at the time of the issuing of this Certificate.
8. Whether the member has in the six years preceding the issuance of this Certificate been the subject of proceedings before the Discipline Committee or Fitness to Practise Committee and the outcome of those proceedings.
9. Whether any restriction or cancellation of privileges by a Board of Governors of a hospital in Ontario, because of incompetence, negligence or any form of professional misconduct within the ten years preceding the date of the Certificate appears in the records of the College.
10. Any other information respecting the member which has been reported to the College and which is deemed by the Registrar to be relevant to a present application for hospital privileges.

**Note: The information provided in this Certificate can be furnished to the requesting institution only where the member physician has fully completed and signed the form of consent, which forms part of this document.**

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### Fee Payment (Certificate cannot be issued until fee of \$50 is paid)

- I authorize the CPSO to charge \$50 to my credit card:  I enclose cheque for \$50
- Visa       MasterCard       American Express

Card number

Expiry Date (MM/YY)

\_\_\_\_\_ *Cardholder signature*

**Please print out this form and sign above**

Member's CPSO number

Member name

Name of Institution