Application for Appointment

To the Credentialed Professional Staff of
London Health Sciences Centre (LHSC) and St. Joseph's Health Care London (St. Joseph's)

DEMOGRAPHIC INFORMATION

Last Name	First Name and Init.	Birth date (mm/dd/yyyy)	Gender / Other	Birthplace	Citizenship

Business Name/Address	Postal Code	Phone (Ext.)
		Facsimile
Current Home Address - If address will change prior to or upon commencement of your start date, please update your records with Medical Affairs.	**Postal Code**	**Telephone**

Email Address	OHIP Billing #

Professional Liability Insurance: Please provide written verification of your liability membership coverage.

☐ **Liability Membership #** _____ **Type of Work Code#** _____

CERTIFICATE OF REGISTRATION/LICENCE

	Registration Date	Registration Type* (see above)	Registration Number
College of Physicians and Surgeons of Ontario*			
College of Dental Surgeons of Ontario			
College of Midwives of Ontario			

FELLOWSHIP CERTIFICATION

	Specialty	Date
Royal College of Physicians and Surgeons of Canada		
Royal College of Dentists of Canada	**Date**	
Royal College of Dental Surgeons of Canada	**Date**	
College of Midwives of Ontario	**Date**	
College of Family Physicians of Canada	**Date**	
Other and/or additional certifications. Please specify:	**Date**	

PREMEDICAL EDUCATION

University	City	Degree	Date of Graduation

MEDICAL / MIDWIFERY / DENTAL EDUCATION

University	City	Degree	Date of Graduation

POSTGRADUATE EDUCATION

University	City	Degree	Date of Graduation

ADDITIONAL DIPLOMAS/DISTINCTIONS

University	City	Degree/Diploma/ Distinction	Date Obtained

Please attach a copy of your curriculum vitae with this application.

DECLARATION INFORMATION

	YES	NO
In the past 12 months, has your **Certificate of Registratio**n to practice medicine, dentistry or midwifery been revoked, suspended, voluntarily surrendered or subject to probationary terms? If '**YES', please give full details below:**	○	○
In the past 12 months, have you maintained your **Membership** with the RCPSC, CMO, RCDSO or CFPC (where applicable) including payment of membership dues? If '**NO', please give full details below:**	○	○
In the past 12 months, have you been subject to any pending or completed reprimand or disciplinary action, professional misconduct, competency investigations or mid-term suspension by any College, hospital or administrative agency related to your professional work? If '**YES', please give full details below:**	○	○
In the past 12 months, have you been charged with or convicted of a criminal offence? If '**YES', please give full details below:**	○	○
In the past 12 months, has any civil claim or suit for alleged malpractice resulted in payment by you, or on your behalf by the CMPA and/or any insurance company? If '**YES', please give full details below:**	○	○
Do you now have any illness, physical disability, or substance dependence that impairs your ability to practice medicine, dentistry, or midwifery? If '**YES', please give full details below:**	○	○

PLEASE READ CAREFULLY

If appointed to the Professional Staff of London Health Sciences Centre (LHSC) and St. Joseph's Health Care London (St. Joseph's), I agree to have read and govern myself in accordance with the provisions and the requirements set out in the Public Hospitals Act of Ontario, as well as other relevant legislation, the Professional Staff By-Laws, Rules and Regulations, ethical guidelines, policies and procedures of the LHSC and St. Joseph's as well as the Mission, Vision and Values of the hospitals. I will participate in quality and patient safety initiatives by conducting all necessary and appropriate activities for assessing and improving the effectiveness, efficiency and safety of care provided by the Hospital. I am aware that if I do not fulfill my obligations as a member of the Professional Staff, any or all privileges will be subject to cancellation at any time at the discretion of the Board of Directors for LHSC and St. Joseph's.

I agree to inform the Board of Directors of any changes in the type of practice I undertake or in my qualifications or in my legal status to practice my profession in Ontario. I certify that all information submitted by me in this application is true to my best knowledge and belief. I understand that the provision of false information is sufficient grounds for rejection of this application or cancellation of privileges already granted. I certify that the professional liability protection identified in this application will be maintained during the period of time that I am a member of the Professional Staff of LHSC and St. Joseph's.

☐ By checking this box, I _____ (Name) agree to the above and certify that all information submitted by me in this application is true to my best knowledge and belief.

AUTHORIZATION FOR RELEASE OF INFORMATION

1. I, _____ acknowledge that I am making formal application for a
   (PRINTED NAME)
   Professional Staff appointment and privileges at London Health Sciences Centre (LHSC) and St. Joseph's Health Care London (St. Joseph's).

2. I hereby consent to the inspection of all records and documents from any health care institution that may be material to an evaluation of my professional qualifications and competence to perform the clinical activities requested as well as to evaluate my moral and ethical qualifications for professional staff membership, by duly authorized representatives of the:

   - Medical Affairs Department
   - Chief of the Department (or delegate) being applied for
   - City-Wide Credentials Committee
   - The University of Western of Ontario (as necessary).

3. I hereby authorize any health care institution where I currently hold or have previously held medical/dental/midwifery/extended class nursing affiliation, to release any information, records, or documents concerning my professional competence, ethics, character and other relevant qualifications for professional staff appointment and clinical privileges to the duly authorized representatives, as listed above.

4. I hereby certify that all information submitted for this application is an accurate representation of the current level of my training, experience, capability and competence to practise with the clinical privileges requested. I fully understand and agree as a condition of making this application that any significant misrepresentation, misstatement in or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application. In the event that any appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery will result in summary dismissal from the Professional Staff.

5. I fully understand and agree that I, as an applicant for Professional Staff membership at LHSC and St. Joseph's, am responsible to provide adequate information for proper evaluation of my professional competence characteristics, ethics and other qualifications, and for resolving any doubts about such qualifications.

6. I understand that my application will not be considered until all information contained therein has been verified and until all the required supporting documentation has been received by the Medical Affairs Department for LHSC and St. Joseph's.

☐ By checking this box, I _____ agree to the above "Authorization and Release".
(Name)

Date _____
(mm/dd/yyyy)

This personal information on this form is collected under the authority of the Public Hospitals Act R.S.0 1990, c. P.40. and is used to consider you for appointment to our professional staff. Medical Affairs will announce the arrival of all new professional staff members that have joined LHSC and St. Joseph's (The Page – LHSC; Imprint – St. Joseph's). If you have questions about the collection of this information, contact Gloria Castelo, Professional Staff Planning & Credentialing Specialist, Medical Affairs, 519-646-6100 ext. 75127

Print | Submit Completed Form (Email)