ARC Alternative Route to Certification | VAC La voie alternative à la certification

APPLICATION INSTRUCTIONS AND DOCUMENT CHECK LIST

❑ **Application Form**

Please ensure that all contact information, including e-mail addresses and telephone numbers are current and that they provide direct, easy access to you.

❑ **CFPC Membership Application (if required)**

Applicants who are **not** yet members of the CFPC must enclose a completed membership application.

❑ **Verification of medical registration and/or license**

Applicants must provide a certificate, issued by each medical regulatory authority (MRA) in which the applicant is registered to practice, that will confirm registration or license status (e.g., certificate of standing, certificate of professional conduct). The certificate must be faxed directly to the College by the MRA. The applicant is responsible for any fees required by the medical regulatory authorities to fulfil this request.

❑ **Reference requests**

All applicants must provide references from two colleagues. The applicant should complete Part 1 of each reference request and forward it to their referees. All referees must be physicians who are licensed and in good standing in the same jurisdiction as the applicant. They should have known the applicant for at least two years. At least one referee should also be a member of the College of Family Physicians of Canada who holds the CCFP designation. Completed reference request forms should be sent directly to the CFPC by the referees. Please do not return them with your application form.

❑ **Program Fee: $2,185**

The fee for the program must be submitted in full at the time of application. Payment may be made by cheque or credit card. Refunds of the fee are subject to penalties for withdrawal from the program. There is a minimum administrative fee of $300.00 for any candidate who submits an application. Candidates who withdraw prior to the completion of the program, but have completed some components will be subject to additional administrative fees. A schedule of our refund policy can be found on our website at www.cfpc.ca.

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APPLICATION FORM

CFPC Membership Number # _______________
(Membership application must be enclosed if you are not a member of the College of Family Physicians)

Preferred language of correspondence English ☐ French ☐

CONTACT INFORMATION

Family Name	Given Names
Date of Birth Year: Month: Day:	Gender Male ☐ Female ☐
Home Address– Apt. No. or PO Box, Street No. and Name	
City	Province
Postal Code	E-mail
Office Telephone	Home Telephone
Cell or Pager	Fax

Please ensure that the College of Family Physicians of Canada is notified of any changes in your contact information.

MEDICAL REGISTRATION INFORMATION

Include all registration numbers authorizing independent practice for the last 5 years to present. Use a separate sheet of paper if required.

Registration Number	Date Issued	Location Province/Territory/State/Country
	From: To:	
	From: To:	
	From: To:	
	From: To:	

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PRIMARY MEDICAL QUALIFICATION

University / Medical School / College	
City	Country
Degree Obtained	Graduation Date Year: Month: Day:
Name on Diploma	Diploma Issue Date Year: Month: Day:

POSTGRADUATE MEDICAL TRAINING

University / Medical School / College	
City	Country
Degree Obtained	Graduation Date Year: Month: Day:
Name on Diploma	Diploma Issue Date Year: Month: Day:
University / Medical School / College	
City	Country
Degree Obtained	Graduation Date Year: Month: Day:
Name on Diploma	Diploma Issue Date Year: Month: Day:
University / Medical School / College	
City	Country
Degree Obtained	Graduation Date Year: Month: Day:
Name on Diploma	Diploma Issue Date Year: Month: Day:

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DESCRIPTION OF CURRENT PRACTICE

Location	
Address – Apt. No. or PO Box, Street No. and Name	
City	Province
Please provide a description of your practice including any areas of special interest (i.e., emergency medicine, palliative care, care of the elderly, etc.)	

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PRACTICE HISTORY

Total number of years in full-time active family practice in Canada ____________ elsewhere ____________

Please provide the locations in which you were in full-time active practice for the last 5 years in chronological order beginning with the most recent. Attach additional pages as necessary.

Medical Centre (clinic or hospital name)	
Address – Apt. No. or PO Box, Street No. and Name	
City	**Province**
Focus of Practice (i.e. family medicine, emergency medicine, etc)	**Length of Time**
Start Date **Year: Month: Day:**	**End Date** **Year: Month: Day:**

Medical Centre (clinic or hospital name)	
Address – Apt. No. or PO Box, Street No. and Name	
City	**Province**
Focus of Practice (i.e. family medicine, emergency medicine, etc)	**Length of Time**
Start Date **Year: Month: Day:**	**End Date** **Year: Month: Day:**

Medical Centre (clinic or hospital name)	
Address – Apt. No. or PO Box, Street No. and Name	
City	**Province**
Focus of Practice (i.e. family medicine, emergency medicine, etc)	**Length of Time**
Start Date **Year: Month: Day:**	**End Date** **Year: Month: Day:**

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PRACTICE HISTORY (continued)

Medical Centre (clinic or hospital name)	
Address – Apt. No. or PO Box, Street No. and Name	
City	Province
Focus of Practice (i.e. family medicine, emergency medicine, etc)	Length of Time
Start Date Year: Month: Day:	End Date Year: Month: Day:
Medical Centre (clinic or hospital name)	
Address – Apt. No. or PO Box, Street No. and Name	
City	Province
Focus of Practice (i.e. family medicine, emergency medicine, etc)	Length of Time
Start Date Year: Month: Day:	End Date Year: Month: Day:

BREAKS IN PRACTICE HISTORY (if applicable)

Please complete if you had any gaps in your practice history for three continuous months or more in the last five (5) years of full-time active practice (attach additional pages as necessary).

Reason for Break (e.g. maternity leave, vacation, emigration)	
Start of Break Year: Month: Day:	Date Break Ended Year: Month: Day:
Reason for Break (e.g. maternity leave, vacation, emigration)	
Start of Break Year: Month: Day:	Date Break Ended Year: Month: Day:
Reason for Break (e.g. maternity leave, vacation, emigration)	
Start of Break Year: Month: Day:	Date Break Ended Year: Month: Day:

DECLARATION

I declare that I am the true holder of the credentials detailed herewith and authorize the College of Family Physicians to consult with other educational and licensing authorities to verify documentation submitted if necessary.

Signature	Date

MAINTENANCE OF CERTIFICATION

I will meet the requirements for continuing membership in the College of Family Physicians of Canada, and failing to do so, I understand that I forfeit the right to use the CCFP as part of my credentials.

Signature	Date

Name (please print)

The completed application along with supporting documentation should be returned to:

ARC Program Coordinator
The College of Family Physicians of Canada
2630 Skymark Ave
Mississauga ON L4W 5A4

Please refer to APPLICATION INSTRUCTIONS AND DOCUMENT CHECK LIST to ensure that your application is complete.

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REFERENCE REQUEST

All referees must be physicians who are licensed and in good standing in the same jurisdiction as the applicant. They should have known the applicant for at least two years.

At least one referee should also be a member of the College of Family Physicians of Canada who holds the CCFP designation.

Part 1 (to be completed by the Applicant)	
Full Name of Applicant (please print)	
Full Name of Referee (please print)	
I hereby authorize the referee stated above to disclose to the College of Family Physicians of Canada information relevant to my eligibility for Certification in Family Medicine. Signature:	Date:

Part 2 (to be completed by the Referee)	
In what capacity have you worked with the applicant? (e.g., Chief of Staff, Program Director, colleague, etc.)	
For how long have you worked with the applicant in this capacity?	
To your knowledge, is this physician in good standing in the medical and general community?	☐ yes ☐ no
Does the physician's practice meet the following description? *For purposes of eligibility for the alternative route, each eligible candidate must be a family physician actively involved in a medical practice in which he/she is currently providing ongoing medical care for patients for a number of different medical presentations.*	☐ yes ☐ no
Further comments in support of the applicant's application for certification in family medicine may be provided in the space below. (Use a separate sheet if necessary)	
Signature of Referee	Telephone number
Referee's CFPC membership identification number (if applicable)	

Completed forms should be sent directly by the referee to:

ARC Program Coordinator, The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, ON L4W 5A4 FAX: 905 629 0893

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CREDIT CARD PAYMENT AUTHORIZATION FORM

The fee for the program must be submitted in full at the time of application.

Payment may be made by cheque or credit card.

Refunds of the fee are subject to penalties for withdrawal from the program. There is a minimum administrative fee of $300.00 for any candidate who submits an application. Candidates who withdraw prior to the completion of the program, but have completed some components will be subject to additional administrative fees.

A schedule of our refund policy can be found on our website at www.cfpc.ca

PROGRAM FEES: $2, 185

Applicant's Name	Membership ID

☐ CHEQUE ENCLOSED ☐ VISA ☐ AMEX ☐ MASTERCARD

Card Number	Expiry Date
Name as it appears on the card (please print)	
Signature	Date