

MEDICAL PROFESSION ACT

Post Graduate Education Medical Licence Application

Personal Inforn	nation								
Last Name				First N	ame				
Date of Birth				Telephone					
Email address						•			
Full Mailing Ad	dress								
Street / Box					City	,			
Province / Terr	rovince / Terr		Co	ountry			ı	Postal Code	
	•		•		•			•	•
Medical School	Informa	ation							
Title of Degree					Date	Grante	d		
School				City				Province	
Country									
MINC#			I		Date	Grante	d		
LMCC#					Date	Grante	d		
	I								
Postgraduate (F	Residen	cy) Inform	atio	on					
I am in my	ear of a	prog	gram	in the fi	eld of				
through the Univers									
		I							
Elective Inform	ation								
Yukon Supervisor					Yukon Clinic				
Dates in Yukon					to				
Dates III Tulkoti				1.0					

Personal information is collected, used, and disclosed under the authority of Section 15(a)-(c) of the Access to Information and Protection of Privacy Act and under the Act associated to the profession related to the licence or certificate being requested. It will be used for the purposes of these Acts and their regulations including but not limited to eligibility of registration and licensure, practice assessment, and complaint related matters. It will also be used to maintain a public register and for research and statistical purposes related to human resource planning. The latter is shared in a non-identifiable form only. For further information about the collection of this information, contact Professional Licensing and Regulatory Affairs (PLRA), Community Services, Government of Yukon, by mail at P.O. Box 2703, Whitehorse, YT, Y1A 2C6, or by phone at 867-667-5111



MEDICAL PROFESSION ACT

Post Graduate Education Medical Licence Application

Declarations of Post Graduate Licence Applicant	Initial here
I hereby apply for registration for a license to practice medicine under the	
Yukon Educational Register pursuant to section 9 of the Medical Professions	
Act, as a post-graduate physician in training.	
If, prior to the issuance of the certificate there is any change in the	
information provided in this application, I will immediately inform the	
Council and provide details of the change.	
I authorize the Yukon Medical Council to make any inquires about me as it	
considers appropriate in connection with this application.	
I confirm that I hold and will continue to hold current and valid CMPA	
insurance coverage in my home jurisdiction for the duration of this elective.	
I agree that I will prescribe medication, including narcotics to patients seen	
under the auspice of my training program abiding by the Yukon Medical	
Council's Prescription Standard, and that all prescriptions I write will include	
my name, my supervisor, and my level of training.	
I declare that I am the person referred to in the application all the	
information provided in this application is true	
Full Name Signature C	Oate
Full Name Signature [To be completed by Program Director	Oate
To be completed by Program Director	ng with our
To be completed by Program Director Dr is a postgraduate trainee in good standing the standard of the	ng with our e.
To be completed by Program Director Dr is a postgraduate trainee in good standing Institution and is approved for the Yukon elective for the dates indicated above. The applicant is approved to prescribe medication under the administration of	ng with our e. Ttheir Yukon
To be completed by Program Director Dr	ng with our e. Ttheir Yukon

Personal information is collected, used, and disclosed under the authority of Section 15(a)-(c) of the Access to Information and Protection of Privacy Act and under the Act associated to the profession related to the licence or certificate being requested. It will be used for the purposes of these Acts and their regulations including but not limited to eligibility of registration and licensure, practice assessment, and complaint related matters. It will also be used to maintain a public register and for research and statistical purposes related to human resource planning. The latter is shared in a non-identifiable form only. For further information about the collection of this information, contact Professional Licensing and Regulatory Affairs (PLRA), Community Services, Government of Yukon, by mail at P.O. Box 2703, Whitehorse, YT, Y1A 2C6, or by phone at 867-667-5111

YUKON MEDICAL COUNCIL

MEDICAL PROFESSION ACT

Post Graduate Education Medical Licence Application

- All forms must be submitted to the Yukon Medical Council at YMC@Yukon.ca along with a copy of one piece of Government issued identification.
- Applicants are responsible for contacting the Yukon Hospital Corporation's privileging department at yhchospitalprivileges@wgh.yk.ca.
- The YMC does not have a role in housing, travel, or reimbursement arrangements for licencees.
- There is no fee for an educational licence.

Yukon Medical Council, Government of Yukon Box 2703 (C-18), Whitehorse, Yukon Y1A 2C6 867-667-3774 YMC@yukon.ca