YUKON MEDICAL COUNCIL

MEDICAL PROFESSION ACT

MEDICAL POST-GRAD REGISTRATION APPLICATION

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

Name (last, first)	
Present address	
Contact phone number	
Contact email	
Date of birth	
Name of primary supervisor	
Yukon clinic	
Dates of Yukon rotations	

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 ☐
Other examinations	Yes ☐ No ☐		Yes ☐ No ☐

LMCC #	
Date issued	
MINC #	

Yukon Medical Council
307 Black Street, Whitehorse, Yukon Y1A 2N1
Mailing: PO Box 2703, C-18, Whitehorse, Yukon Y1A 2C6

Email: ymc@yukon.ca
Phone: 867.667.5111
Fax: 867.393.6483

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

I am in my _____ year of a _____ year program.
If you are in the 1st year of your residency program, indicate the number of months you have completed.

Residency program is in what field? _____

To assist with your hospital privileges application

☐ Check if you wish our office to forward copies of your CMPA and program director's letter to the Yukon Hospital Corporation.

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

All applications must be submitted to YMC.
Processing time: up to 30 days.

Email: ymc@yukon.ca **Fax:** 867-393-6483	**Courier or bring in person to:** Yukon Medical Council 1st floor - 307 Black Street Whitehorse, Yukon Y1A 2N1	**Mail to:** Yukon Medical Council Box 2703, C-18 Whitehorse, Yukon Y1A 2C6