

**Post Graduate Education Medical Licence Application**

<b>Personal Information</b>			
Last Name		First Name	
Date of Birth		Telephone	
Email address			

<b>Full Mailing Address</b>					
Street / Box			City		
Province / Terr		Country		Postal Code	

<b>Medical School Information</b>					
Title of Degree			Date Granted		
School		City		Province	
Country					
MINC #			Date Granted		
LMCC #			Date Granted		

<b>Postgraduate (Residency) Information</b>					
I am in my		year of a		program in the field of	
through the University of					

<b>Elective Information</b>			
Yukon Supervisor			Yukon Clinic
Dates in Yukon			to

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<b>Declarations of Post Graduate Licence Applicant</b>	<b>Initial here</b>
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 inquiries 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 \_\_\_\_\_ Date \_\_\_\_\_

**To be completed by Program Director**

Dr. \_\_\_\_\_ is a postgraduate trainee in good standing with our Institution and is approved for the Yukon elective for the dates indicated above.

The applicant is approved to prescribe medication under the administration of their Yukon Supervisor.    ☐ YES    ☐ NO    ☐ N/A

I will notify the Council in writing of any concerns with respect to the competency of the applicant.

Name and Title of Program Director \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Contact email address \_\_\_\_\_



## MEDICAL PROFESSION ACT

### Post Graduate Education Medical Licence Application

- All forms must be submitted to the Yukon Medical Council at [YMC@Yukon.ca](mailto: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](mailto: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](mailto:YMC@yukon.ca)