

## **MEDICAL PROFESSION ACT**

## **Student Education Medical Licence Application**

Personal Inform	nation								
Last Name	lation		First Na	ıme					
Date of Birth			Telephone						
Email address			Тетери	JIIC					
Lillali addie33									
Full Mailing Add	dress								
Street / Box				City					
Province / Terr		Cou	ıntry			F	Postal C	Code	
		1							
D 1f									
Program Inform	aπon								
Medical School									
City			Pro	ovince/Sta	ate				
Country									
Start date		Expected Graduation							
			l .						
Elective Informa	ation								
Yukon Supervisor			Yuk	on Clinic					
Dates in Yukon			to		•				
	-		•	•					
Declarations of Medical Student Licence Applicant								Initi	ial Here
I hereby apply for registration for a license to practice medicine under the									
	Register pursuant to		-						

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.

Act, as a medical student physician in training.

Council and provide details of the change.

If, prior to the issuance of the certificate there is any change in the information provided in this application, I will immediately inform the

considers appropriate in connection with this application.

I authorize the Yukon Medical Council to make any inquires about me as it



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information provided in this a	referred to in the application all the application is true.	e
Full Name	Signature	Date
	versity Dean or equivalent is a medical student in goo	od standing with our
Institution and is approved fo	or the Yukon elective for the dates in udent is fully covered by the Univers	ndicated above.
I will notify the Council in wri applicant.	ting of any concerns with respect to	the competency of the
Name and Title of Program D	irector	Date
Signature	Contact email address	·

- All forms must be submitted to the Yukon Medical Council at <a href="YMC@Yukon.ca">YMC@Yukon.ca</a> 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 <a href="mailto:YMC@yukon.ca">YMC@yukon.ca</a>