FAMILY PRACTICE PROGRAMS APPLICATION

APPLICANT INFORMATION

Surname:_____ Given Name:_____ Initial:____

Social Insurance Number:_____ Date of Birth (DD/MM/YYYY):_____

Current Mailing Address:_____

Telephone: _____ Email:_____

COMMUNITY OF PRACTICE INFORMATION

Community of Practice:_____

Name of Family Practice:_____

Practice Start Date (DD/MM/YYYY):_____

TYPE OF FAMILY PRACTICE

☐ The applicant will establish a new family practice.

☐ The applicant will join an established family practice.

FUNDING PROGRAM

☐ Application for funding under the **New Family Physician Income Guarantee.**

☐ Application for funding under the **Family Practice Start-up Program.**

☐ Application for *Medical Resident Bursary Program Rollover* funding under the **Family Practice Start-up Program.**

SUPPORTING DOCUMENTATION:

- ☐ Letter of offer from an established family practice outlining the start date, location of practice, and confirmation of the amount of time that will be dedicated to providing comprehensive, continuous care to patients at the practice (*for applicants joining an existing family practice only*).
- ☐ Letter outlining the approximate opening date, location of practice, and confirmation of the amount of time that will be dedicated to providing comprehensive, continuous care to patients at the practice (*for applicants starting a new family practice only*).

DECLARATION BY APPLICANT

I certify that all information given on this application is complete and true to the best of my knowledge.

I acknowledge that the Department of Health and Community Services is collecting the information contained in and included with this form for the purposes of considering and approving my application for funding under the Family Practice Program, which is designed to attract and retain new, qualified family physicians to provide primary health care services in the Province of Newfoundland and Labrador. I authorize the Department to collect my personal information and to use and disclose such information to other parties as it considers necessary for the purposes of considering and approving this application and assessing the efficacy of this program.

I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate repayment of current funding and disqualification from receiving future incentives. The Department of Health and Community Services has my consent to the collection, use and disclosure of my personal information in accordance with the ***Access to Information and Protection of Privacy Act, 2015****.*

Applicant Signature:_____ Date:_____

PROVINCIAL HEALTH AUTHORITY APPROVAL

Regional Physician Recruiter:_____

Signature:_____ Date:_____

COMPLETED APPLICATIONS CAN BE RETURNED VIA MAIL OR EMAIL TO:

Medical Services Division
Department of Health and Community Services
1st Floor, West Block, Confederation Building
P.O. Box 8700, St. John's, NL A1B 4J6
MedServicesPrograms@gov.nl.ca