UKRAINIAN PHYSICIAN LICENSURE SUPPORT PROGRAM

APPLICANT INFORMATION

Surname:_____ Given Name:_____ Initial:_____

Citizenship: _____ Date of Birth (DD/MM/YYYY):_____

Current Mailing Address:_____

Telephone: _____ Email:_____

MEDICAL EDUCATION

Medical School:_____

Post-Graduate Training Program:_____

ELIGIBILITY

- ☐ The applicant has a medical degree from a medical school listed in the *World Directory of Medical Schools*.
- ☐ The applicant has completed a discipline-specific post-graduate training program.
- ☐ The applicant has practiced medicine for a minimum of 120 days in the past 3 years.
- ☐ The applicant was living and working or training in Ukraine as a physician and is currently residing in Newfoundland and Labrador as a result of displacement due to the conflict with Russia.

TYPE OF PRACTICE

☐ The applicant will practice Family Medicine/General Practice.

☐ The applicant will practice as a Specialist.

Note: There are different pathways to licensure for Specialists and Family Physicians in Newfoundland and Labrador. Please see here for more information including eligibility requirements.

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 ***UKRAINIAN PHYSICIAN LICENSURE SUPPORT PROGRAM****, which is designed to assist Ukrainian physicians in obtaining a licence to practice medicine in the Province of Newfoundland and Labrador. This information is being collected under the authority of section 61(c) of the* ***Access to Information and Protection of Privacy Act, 2015****.*

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, my eligibility for benefits under the program, 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. If you have any questions about how this information will be collected, used and disclosed, please contact Wendy Snow, Manager of Recruitment, Department of Health and Community Services, 709-729-5864 or WendySnow@gov.nl.ca.

Applicant Signature:_____ Date:_____

COMPLETED APPLICATIONS CAN BE RETURNED VIA MAIL OR EMAIL TO:

Office of Health Professional Recruitment and Retention
Department of Health and Community Services
1st Floor, West Block, Confederation Building
P.O. Box 8700, St. John's, NL A1B 4J6
UkrainianPhysician@gov.nl.ca