CARE OF THE ELDERLY INCENTIVE APPLICATION

APPLICANT INFORMATION

Surname:_____ Given Name:_____ Initial: _____

Current Mailing Address:_____

Telephone: _____ Email:_____

Start Date of Care of the Elderly Program (DD/MM/YYYY) _____

Finish Date of Care of the Elderly Program (DD/MM/YYYY) _____

ELIGIBILITY

Applicants will be required to submit proof of the following eligibility criteria in addition to this application form:

- ☐ The applicant has been accepted into the Care of the Elderly Program at Memorial University (attach confirmation)
- ☐ The applicant has been practicing family medicine in any jurisdiction prior to entering the Care of the Elderly program (i.e. physicians who enter directly into the COE training program from a family medicine residency training program are not eligible).
- ☐ The applicant holds a license with the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL).
- ☐ The applicant commits to practicing family medicine in Newfoundland and Labrador upon program completion for a two year period.

Please do not provide any unnecessary personal information or documentation that has not been explicitly requested.

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 (the Department) is collecting the information contained in and included with this form for the purposes of considering and approving my application for funding under the ***Care of the Elderly Incentive Program****, which is designed to provide financial assistance to practicing physicians who choose to return to Memorial University to complete the enhanced skills training program in Care of the Elderly (COE). 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 EMAIL TO:

Office of Health Professional Recruitment and Retention
Department of Health and Community Services
HCSIncentives@gov.nl.ca