Provincial Locum Recruitment Program Application

Physicians Interested in Providing Locum Services - Private Practice Clinics

APPLICANT INFORMATION

Surname: Given Name: Initial:

Date of Birth (DD/MM/YYYY):_______________ Provider Number:

Current Mailing Address:

Telephone: Email:

PRACTICE INFORMATION

Physician Specialty:

The length of locum you are willing to provide:

Dates available: (DD/MM/YYY) to DD/MM/YYY)

Practice location of interest (i.e. urban, rural, remote):

SUPPORTING DOCUMENTATION:

CV

Proof of eligibility for licensure with the College of Physicians and Surgeons of Newfoundland and Labrador

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 establishment and maintenance of a provincial physician locum roster, designed to attract qualified physician locums to provide 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 establishment and maintenance of a provincial physician locum roster 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 removal from the provincial physician locum roster. The Department of Health and Community Services has my consent to the collection, use and disclosure of my personal information in accordance with section 61(c) of the **Access to Information and Protection of Privacy Act, 2015**.

I would like for my contact information to be shared with NL Health Services (including physician recruiters) to further facilitate recruitment.

Applicant Signature: ______________________________ Date: _____________

Please do not include any unnecessary personal information when submitting this application.

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