MEDICAL LICENSURE PROGRAM FOR INTERNATIONAL MEDICAL GRADUATES (MPLIMG)

ADDITIONAL INFORMATION

- **For the 2008 assessment intake, applicants will require a valid unexpired pass standing on the Medical Council of Canada Evaluating Examination.**

IMPORTANT DATES

❑ March 31/08	IMG application deadline
❑ Mid May 08	IMGs will be advised of acceptance for CAPE
❑ Mid June /08	CAPE Preparation Course
❑ September 4, 5, 6/08	CAPE
❑ Mid October /08	CAPE results sent to IMG Director
❑ November /08	IMGs will be advised of CAPE results and next steps
❑ December /08	Orientation Program under development, details to follow
❑ January /09	Eligible IMGs to begin enhanced training (medical practice to begin upon satisfactory completion of enhanced training).

MEDICAL LICENSURE PROGRAM FOR INTERNATIONAL MEDICAL GRADUATES (MLPIMG) APPLICATION FORM

Please type or print clearly.

Name: _____ Birth Date: _____ _____ _____
Day Month Year

Address: _____ Postal Code: _____

Contact Address: _____ Postal Code: _____

Telephone: (home) _____ (work) _____

(fax) _____ (email) _____

Citizenship: _____ If not Canadian citizen, landed immigrant: _____ _____
Yes No

Resident of Manitoba: _____ _____ Date of Permanent Move to Manitoba: _____
Yes No Month/Year

Medical Council of Canada (MCC) Evaluating Examination: _____
(Include notarized photocopy of letter from MCC) Month/Year Passed)

Medical Council of Canada (MCC) Qualifying Examination Part I: _____
(Include notarized photocopy of letter from MCC) (if applicable) (Month/Year Passed)

Medical School: _____
(Name - Location - Month/Year of Graduation)

Graduate Medical Education: _____
(Area of Medical Training - Medical School - Month/Year Started - Month/Year Completed)

_____
(Area of Medical Training - Medical School - Month/Year Started - Month/Year Completed)

_____
(Area of Medical Training - Medical School - Month/Year Started - Month/Year Completed)

_____
(Area of Medical Training - Medical School - Month/Year Started - Month/Year Completed)

Postgraduate Degrees/Qualifications Granted:_____

Previous Practice Experience: _____
(Area of Practice - Location - Month/Year Started - Month/Year Completed)

_____
(Area of Practice - Location - Month/Year Started - Month/Year Completed)

_____
(Area of Practice - Location - Month/Year Started - Month/Year Completed)

Last month/year of active medical practice, and location: _____

Currently Working: _____ _____ Type of Work: _____
Yes No

_____ _____
Signature Date

- In accordance with the Human Rights Act of Manitoba, you may but are no longer required to include a photograph with this application. However, if you are accepted to take the CAPE, upon notification of acceptance you will be required to provide the Program Director with a passport size photograph (with your signature on the front) to establish that you are the person represented by the documents. Proof of any change of name, if it is different from the one on your documentation, must also be provided.
- You will be required to provide photo identification on the first day of the assessment. PLEASE BRING YOUR PASSPORT TO THE ASSESSMENT TO CONFIRM YOUR IDENTITY.

MEDICAL LICENSURE PROGRAM FOR INTERNATIONAL MEDICAL GRADUATES (MLPIMG)

AUTHORIZATION OF RELEASE OF REPORT OF ASSESSMENT

I,_____(name), authorize the Department of Continuing Medical Education, The University of Manitoba, to release a copy of the "Report of Assessment", resultant from my participation in the Clinicians Assessment and Professional Enhancement Program (CAPE), to the Director of the IMG Program (IMGP).

Signature _____ Date _____

Witness _____

MEDICAL LICENSURE PROGRAM FOR INTERNATIONAL MEDICAL GRADUATES (MLPIMG)

AUTHORIZATION OF RELEASE OF INFORMATION

I,_____ (name), authorize the College of Physicians and Surgeons of Manitoba (CPSM), to release information regarding my Applications that I have made to The College of Physicians and Surgeons of Manitoba (CPSM) to the Director of the IMG Program (IMGP).

Signature _____ Date _____

Witness _____

CANADA	**)**	I,_____,
	)	of the City of Winnipeg, in the Province of
PROVINCE OF MANITOBA	**)**	Manitoba,
	)	
TO WIT:	**)**	

MAKE OATH AND SAY THAT:

1. I have applied to the Medical Licensure Program for International Medical Graduates at the University of Manitoba (MLPIMG).

2. I have resided, and continue to reside in Manitoba, continuously for six months, without interruption, prior to the CAPE Assessment.

3. The foregoing is true and accurate, and I have been advised that should the foregoing not be true and accurate, I may be withdrawn from the CAPE Assessment or the Medical Licensure Program for International Medical Graduates and reported to the College of Physicians and Surgeons of Manitoba, and I may face other legal consequences.

4. I make this affidavit *bona fide.*

SWORN before me at the City	)	
of Winnipeg, in the Province of	)	
Manitoba, this _____day	)	
of _____, 20	)	
_____	)	_____
A Commissioner for Oaths		*Name:*
in and for the Province of Manitoba		
my commission expires:		

_____

CERTIFICATE OF PREREGISTRATION PHYSICIAN TRAINING

Physicians are required to provide evidence of satisfactory completion of a 12 month postgraduate clinical training program in a hospital affiliated with an approved faculty of medicine and which meets the following conditions:

1. (a) that the physician was enrolled in a university teaching program
   (b) in a hospital affiliated with an approved faculty of medicine whose faculty are on-site, and which provided
   (c) supervision and formal evaluation by the teaching staff and which
   (d) is recognized for the purposes of registration in the jurisdiction of graduation.

2. That during a one year postgraduate training program, the core content (8 weeks each in medicine, surgery, obstetrics, pediatrics) was under the direction of a single program director.

3. Please also include evidence of any additional postgraduate medical training you may have received.

TO BE COMPLETED BY DEAN OR POSTGRADUATE TRAINING DIRECTOR and returned directly to the College of Physicians & Surgeons of Manitoba, 1000-1661 Portage Avenue, Winnipeg, MB, Canada, R3J 3T7.

THIS IS TO CERTIFY THAT

_____
(name)

was enrolled in a university teaching program and has satisfactorily completed a program of postgraduate clinical training at

_____
(name of university) and (name of hospital)

from

_____
(inclusive dates)

which meets the conditions as outlined in items 1 and 2 above, and which contained the following rotations for the number of weeks indicated (please include **all** rotations, including vacation, completed during the one year program):

General Medicine ……
General Pediatric Medicine …….
Others……
Obstetrics/Gynecology ……...
General Surgery …….

_____ _____
Date Name

_____
Seal Title

Instructions to Program Applicants:

1. Send this form, as soon as possible, to the medical school at which you completed your postgraduate medical training.
2. Along with your application for the MLPIMG program, please provide the contact names, addresses, positions, phone and fax numbers, and e-mail addresses of individuals at the medical school at which you completed your postgraduate medical training. Keep a copy of this information for yourself.