Keewatin Yatthé Regional Health Authority

Application for Re-Appointment to the Practitioner Staff

April 1, 2016 to March 31 , 2017

Return this form to:
KYRHA Office,
Box 40,
Buffalo Narrows, Sk.
S0M 0J0

Phone 306-235-2220
Fax: 306-235-2229

DEADLINE FOR RETURN OF THIS DOCUMENT IS MARCH 31, 2015

Name	Surname	Given name(s)	
Office Address			
Home Address			
Telephone	Office ( )	Home ( )	
	Fax ( )	Cell ( )	
Email		**APPOINTMENT Category** (current)	

Please read carefully and ensure all questions are answered:	**YES**	**NO**
1. If you do not wish to apply for reappointment please indicate: ☐ Resign ☐ Retire	Date effective	
2. Appointment – Do you wish to apply for appointment to your same practitioner staff category? *(Current Category noted above)* ***See below***	☐	☐
3. Privileges – Do you require any changes to your current privileges? ***See next page***	☐	☐
4. Are you aware of any health condition that could affect your ability to carry out your Practitioner Staff responsibilities? *If YES, attach list of functions you cannot perform and accommodations requested.*	☐	☐
5. Do you hold current liability insurance coverage? *(e.g. Canadian Medical Protective Association)* ***Please provide a photocopy of proof of membership (with Code indicated)***	☐	☐
6. Do you hold a current license with your professional licensing body? *(i.e. CPSS)* ***Please provide a photocopy of proof of current licensure***	☐	☐
7. Are you in good standing with the Regional Health Authority health records department?	☐	☐
8. If the answer to any of the following is YES, provide full details (including dates) on separate paper. *Provide information as it pertains to the **period since your last application for appointment only***		
• Has your license to practice been limited, suspended or revoked or does any action or proceeding exist which could lead to that result?	☐	☐
• Have you been, or are you now, subject to disciplinary action or proceedings by your professional licensing body?	☐	☐
• Have there been any claims initiated, settlements negotiated or judgments entered against you in relation to any malpractice action?	☐	☐
• Have you ever been convicted of any criminal offense?	☐	☐
• Are you aware of any pending criminal charges against you?	☐	☐

Family Physicians: **ACLS** Date Certified/Recertified ____________________ (Current certification is expected)

RE-APPOINTMENT	**PRACTITIONER STAFF CATEGORY YOU ARE APPLYING FOR at this time**		
☐ Active	☐ Temporary	☐ Limited	☐ Assistant
☐ Associate	☐ Visiting	☐ Resident	☐ Honorary

PROFESSIONAL INVOLVEMENT and CME *(attach extra paper if needed)*

1. **Please report** any additional training and continuing professional education activities you undertook during the past year not previously reported as part of your continuing professional learning?

____

____

2. Please report any administrative, committee, teaching, research or special responsibilities you assumed or continued during the past year? Any new academic achievement?

Please give details: ______________________________

____

____

DATES **(recent):** **ATLS** __________ **PALS** __________ **NRP/NALS** __________ **ALARM** __________

PRIVILEGES **Indicate any deletions or additions you require** *(Current approved Privileges attached)*

I hereby request that my Privileges be:

a) Continued as present: ☐

b) Changed as follows - Give details of changes you require and reasons for changes.
- Please provide evidence of training and experience in support of any additional privileges you request

DELETE: ____

____

ADD: ____

____

DECLARATION

I, THE UNDERSIGNED, declare that I have undertaken the necessary continuing professional learning to satisfy my professional licensing body requirements.

I, THE UNDERSIGNED, consent that my information, including my personal health information (as per question 4) pursuant to *The Health Information Protection Act*, can be shared with all Saskatchewan regional health authorities.

I, THE UNDERSIGNED, hereby apply for reappointment to the Practitioiner Staff of the Keewatin Yatthe Regional Health Authority with privileges as outlined on the attached sheet. I agree to abide by the Health Region Bylaws and such Rules and Regulations/Policies/Guidelines as may, from time to time, be enacted.

____________	____________________	____________
Date	**Signature**	Logo or Initials (as you identify on records)
____________	____________________	
Date	**SMO / Credential Chair / Designate Signature**	

Comments: ____

DOCUMENTS REQUIRED - PLEASE SUBMIT (current year):

☐ Proof of CMPA Membership

☐ CPSS Licensure

☐ Reappointment Form