Family & Community Medicine
UNIVERSITY OF TORONTO

PROFESSIONAL PROFILE - TEACHING PRACTICES

(1) *Personal Information*

Last Name: | **First Name:** | **Initials:** | **Social Insurance Number:**

Home Address: | **City :** | **Province:** | **Postal code:**

Home Telephone Number: ( ) | **Alternative Number:** ( ) | **E-mail Address:**

Business Address | **City** | **Province** | **Postal Code** | **Business Telephone Number:** ( )

Date of Birth: Day | Month | Year

Sex: ☐ **Female** ☐ **Male**

Citizenship or Immigration Status:

☐ **Canadian** ☐ **Permanent Resident** ☐ **Other, please specify**_____

(2) *Faculty Information*

Member of the College of Family Physicians of Canada (CFPC): (if a member, a photocopy of your membership card is **MANDATORY**)

Yes ☐ No ☐ **Membership Number** : _____ **Expiry Date:** _____ dd/mm/yyyy

Canadian College of Family Physicians (CCFP) Certification (exams):

Yes ☐ No ☐ N/A ☐ (If applicable) **Year of CCFP Exam Completion**: _____

CPSO Certificate of Registration: (a photocopy of CPSO membership card is **MANDATORY**)

Yes ☐ No ☐ **CPSO Number:** _____ **Expiry Date:** _____ dd/mm/yyyy

What type of CPSO registration will you have if your University appointment begins?

☐ Independent Practice Certificate of Registration
☐ Certificate of Academic Registration
☐ Restricted Certificate of Registration
☐ I don't know

Canadian Medical Protective Association Membership (CMPA): (a photocopy of CMPA card is **MANDATORY**)

Yes ☐ No ☐ **CMPA Number:** _____ **Expiry Date:** _____ dd/mm/yyyy

Certificate of Professional Conduct:

☐ Yes (a photocopy of your Certificate of Professional Conduct is **MANDATORY**)

Completion of specialty exams outside of Canada: ⇨ (If applicable) Indicate Country:

Yes ☐ No ☐ _____

Do you have a faculty appointment at any other academic? Institution. (If applicable) Indicate Rank:

Yes ☐ No ☐ ⇨ _____

Have you passed Royal College of Physicians and Surgeons of Canada Specialty Exams?

Yes ☐ No ☐ If yes, which specialties? _____

If yes, which certificate was conferred? ☐ FRCPC ☐ FRCSC ☐ None

Do you hold, or have you ever held, an academic appointment at the university of Toronto?

Yes ☐ No ☐ (If yes) Indicate the department: _____

Do you have a Faculty Appointment at any other Academic Institution?

Yes ☐ No ☐ (If yes) Indicate the rank and institution name: _____

Do you have, or are you seeking, a Hospital Affiliation:

Yes ☐ No ☐ (If yes) Indicate the Hospital: _____

Type of Hospital Appointment Category: _____
(i.e. Active, Courtesy, Associate, Consulting, etc.)

Type of Privileges: _____
(i.e. Administrative, Emergency Medicine, Inpatient Care, Minor procedures, Obstetrics, etc.)

	Year Graduated	**Institution**
Doctor of Medicine (If applicable)	_____	_____
Family Medicine Residency (if applicable)	_____	_____
Other Residency (please be specific) e.g. 2 year Family Medicine residency, 1 year rotating internship, 4 year Internal Medicine residency.	_____	_____

Post Residency Training Completed (If applicable) :
i.e.: fellowships, certificates, diplomas, honours etc.

Additional Professional Contributions(If applicable) i.e. Research endeavours, publications, papers presented at meetings and symposiums, invited lectures and teaching to date, creative professional activities, clinic innovations, guideline development. (Indicate undergraduate, postgraduate. Add page if needed)

Have you been under investigation or found either unfit to practice and/or guilty of professional misconduct by the College of Physicians and Surgeons of Ontario (CPSO) or any other medical/professional licensing body?

Yes ☐ No ☐

Are you presently the subject of an investigation by the CPSO, any other provincial regulatory body, or other medical/professional body?

Yes ☐ No ☐

If you answered yes to any of the above statements, please explain:

*** nb: Please be assured that all professional profiles are kept strictly confidential.**

I understand that this re/appointment application is subject to approval by the Director of Teaching Practices. I agree to discuss with the Department Chair any changes in my professional license status, CMPA status or any other issues that may affect the provision of services including teaching or patient care.

_____ _____
Candidate's Signature *Date*

_____ _____
Program Director's Signature *Date*

Revised: Sept 28 2015

Please return via: **E-mail**: dfcm.teachingpractices@utoronto.ca **Fax**: 416-978-8179 **Mail**: Attention: Fadia Ayoub Department of Family and Community Medicine Toronto, Ontario M5G 1V7
Phone number: 416-978-8530 500 University Ave.