

## WE ARE CURRENTLY ACCEPTING APPLICATIONS FOR THE 2022 EXAM YEAR.

At this time, we will not accept applications for 2023 or later.

### IMPORTANT INFORMATION

- **If deemed eligible for the examination**, you will be provided with 3 consecutive years of eligibility to the examination, beginning with the examination year applied for.
- **Deferrals** will only be granted in exceptional situations. Please refer to section 5.8 of the [Policies and Procedures for Certification and Fellowship](#) for additional information.
- **Renewals:** Please refer to section 5.7 of the [Policies and Procedures for Certification and Fellowship](#) for information on renewals of eligibility.

### PLEASE NOTE

- Receipt of your application will be acknowledged via email within 5 business days
- It takes an average of 6-8 months to complete an assessment of training/practice
- The Royal College will communicate with you via email. Please ensure we have your up-to-date contact information at all times. Information can be updated at [www.royalcollege.ca/coa](http://www.royalcollege.ca/coa)
- Due to the high volume of requests, we ask that you refrain from contacting the Credentials Unit in order to allow for the timely processing of all requests equally and fairly.
- We understand your assessment is important to you and we will make every effort to expedite your request. You will be contacted if additional information is required to process your application.

## CRITERIA TO APPLY

- Specialist training was completed outside Canada and the United States
- Completion of all postgraduate medical education (PGME) training requirements of the jurisdiction in which training occurred.
- Time in training which is equivalent to the [Specialty Training Requirements](#) in your specialty.
- Minimum three (3) years of practice as an independent specialist in the specialty applied for (any jurisdiction) at the time of application.
- Eligibility to practice (or previous practice) as an independent specialist in the country of postgraduate training.

## PLEASE SELECT WHICH OF THE FOLLOWING APPLY TO YOU:

<input type="checkbox"/>	I have between 3 and 5 years of practice as an independent specialist <u>or</u> I have more than 5 years of practice as an independent specialist, but <b>do not have</b> the final 2 years of practice in a current and continuous practice location in Canada
<input type="checkbox"/>	I have more than 5 years of practice as an independent specialist, <b>with the</b> final 2 years of practice in a current and continuous practice location in Canada.

## REQUIRED DOCUMENTATION

Please submit the following documents to the Royal College with your application:

<input type="checkbox"/>	An up-to-date CV which includes the following information: <ul style="list-style-type: none"> <li>• A summary of your practice and training to date</li> <li>• An explanation of any gaps in training or practice longer than three (3) consecutive months</li> </ul>
<input type="checkbox"/>	A copy of your currently medical license to practice ( <i>if currently practicing in Canada</i> )
<input type="checkbox"/>	A certificate of professional standing from your current Medical Regulatory Authority ( <i>if currently practicing in Canada</i> ) <b>This certificate must be ordered by you and sent to the Royal College directly from the MRA.</b>
<input type="checkbox"/>	Details of training rotations completed to date in your specialty (e.g. area of rotation and time spent in this area)
<input type="checkbox"/>	Evidence of language proficiency in English or French

Please submit the following documents to Physicians Apply for source verification.

*Please remember to activate sharing of each document with the Royal College.*

<input type="checkbox"/>	A copy of your medical degree (e.g. MD, MBBS)
<input type="checkbox"/>	Specialty certificate/diploma received from jurisdiction of training showing eligibility to practice as an independent specialist
<input type="checkbox"/>	Specialist licensure for all jurisdictions that you currently hold or have held a license to practice in your specialty
<input type="checkbox"/>	Certificate of professional standing from your current practice location ( <i>if outside Canada</i> )
<input type="checkbox"/>	Internship document
<input type="checkbox"/>	Evidence of postgraduate training completed to date (e.g. completion of training certificate (CCT) or written confirmation from the Program Director of your training program indicating the scope of your training and the start and finish dates) <b>Note: if you trained in a number of location and institutions, please submit documentation for all periods of training.</b>

**PLEASE SEND YOUR COMPLETED APPLICATION FORMS TO ONE OF THE FOLLOWING:**

**Postal address:**

Royal College of Physicians and Surgeons of Canada  
Credentials Unit  
774 Echo Drive  
Ottawa, ON  
K1S 5N8

**Email:** per@royalcollege.ca

**Fax:** (613) 730-3707



Please ensure that you have reviewed the criteria to apply and have completed the application in full prior to submitting

**FEES**

The deadline to submit your application is April 30 of the year before you wish to be examined. Should you submit your application after the deadline, you will be subject to the [non-refundable late penalty fee](#) which is in place at the time your application is submitted.

*There is no guarantee that your application will be processed on time for the examination registration deadline.*

Please see the fee schedule below. A credit card authorization form is included with this application.

Date application received by the Royal College	Fee
Before April 30 of the year before you wish to be examined	\$7,000
Between May 1 and August 1 of the year before you wish to be examined	\$7,710
After August 1 of the year before you wish to be examined	\$8,410

## PERSONAL DETAILS

### Identification

RC ID (if applicable):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Surname:	Date of birth (DD/MM/YY):
Given name:	Middle name:

### Contact information

<input type="checkbox"/> Home address <input type="checkbox"/> Business address	Apartment number:	
Street number and name:		
City:	Province:	Postal code:
<input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Cell	<input type="checkbox"/> Home <input type="checkbox"/> Business	
Phone:	Email:	

### Medical Graduation Diploma

Type of degree (e.g. MD, MBBS):	Year obtained:
University:	
City:	Country:

## CREDIT CARD AUTHORIZATION FORM

*one time use only*

Date:

### Applicant information

Name of applicant:

Amount:

*The Royal College will charge the credit card in \$CAN*

Card type:  Visa  Mastercard  American Express

### Credit card information

Card number:

Expiry date (MM/YY):

Cardholders name:

I agree

By selecting "I agree", the Royal College is authorized to charge the non-refundable assessment fee to the credit card listed above for the amount indicated.



### ROYAL COLLEGE USE ONLY

Date:

Rev. Code:

332

ID number:

Amount:

Agent initials

Rev. Code:

Amount:

## DECLARATION OF UNDERSTANDING & AUTHORIZATION FOR RELEASE OF INFORMATION

### Identification

Surname:

Date of birth (*DD/MM/YY*):

Given name:

Middle name:

Dated at (*city and province*):

By providing my signature, I, the above-named physician, hereby agree to and authorize the following:

### Release of information to your Medical Regulatory Authority (MRA)

I agree that the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") may release and disclose any and all information to the Medical Regulatory Authority ("MRA") in the province or territory in which I hold a medical license and/or registration to practice medicine and other national regulatory authorities, relative to my training history, practice profile, credentialing and examination eligibility, examination and or assessment results including but not limited to my scope of practice description, eligibility details, summary of performance and any ongoing evaluations and outcome. The Royal College may provide to my MRA copies of any and all records in my file. This authorization shall continue until revoked by me in writing.

### Release of information between Pivotal Research and the Royal College

I authorize the Royal College to release my contact information to Pivotal Research Inc. for the purposes of the completion of the Multisource Feedback surveys,

### Sharing of information between your current Chief of Staff/Supervisor and the Royal College

I authorize the person I listed as my Chief of Staff/Supervisor to release any and all information which the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") may request relating to my training history, credentialing, and examination eligibility. I hereby authorize my Chief of Staff/Supervisor to provide to the Royal College copies of any and all records in my file. This authorization shall continue until revoked by me in writing. A photo copy of this authorization shall serve in its stead.

### Consequences of false/fraudulent documentation and/or irregular behaviour

I agree to provide authentic and accurate information and documentation to the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") and to participate in good faith in the assessment process.

I understand that if I provide false/fraudulent documentation to the Royal College or engage in irregular behavior with respect to my assessment, my actions may lead to serious consequences as outlined below.

In the event (i) that any of my information submitted to the Royal College including personal information in any documents in support of my application, including my credentials, is determined or believed by the Royal College not to be authentic or to be false, fraudulent or otherwise deceptive, or (ii) that any such information related to the Royal College submitted to other agencies is determined or believed by them or the Royal College not to be authentic or to be false, fraudulent or otherwise deceptive, or (iii) of any irregular behavior, the Royal College may take appropriate action as it sees fit, including, but not limited to:

- Revoking my eligibility;
- Terminating my assessment and withholding or invalidating my assessment results;
- Barring me from any future Royal College examinations or other assessments; and

Notifying each of the Canadian medical regulatory authorities, in addition to licensing, regulatory, educational, training, resident matching services, credentials verification authorities, hospitals, clinics and other medical facilities and organizations that utilize the services of physicians, government agencies (local, state, provincial, federal or foreign), law enforcement agencies or other third parties and organizations, and their representatives, who in the opinion of the Royal College have a legitimate interest in such information. I acknowledge that this notification or disclosure of information may occur regardless of whether or not I have withdrawn my consent to any other uses or disclosures of my information by the Royal College.

### Confidentiality Agreement

I undertake to respect the confidentiality of the assessment and acknowledge that I understand the following:

Failure to respect the confidentiality of the assessment may be deemed professional misconduct and my assessment results may be voided, and the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") may notify Canadian licensing authorities of the situation.

That the examination questions and scenarios are protected by copyright and are the exclusive property of the Royal College.

That any reproduction, dissemination or other disclosure of the assessment questions and or scenarios in whole or in part is strictly prohibited and that the Royal College may take all available disciplinary measures and legal actions against any candidate or others who violate this confidentiality provision including revocation of eligibility, cancellation of results and prohibition from any other Royal College examination/assessment.



**Immunity and Release**

I hereby extend absolute immunity to, and release, discharge and hold harmless from any and all liability:

- 1) Royal College and its respective employees, agents, representatives, members, directors and officers; (collectively known as the Royal College,) for or in respect of any acts, communications, reports, statements, documents, recommendations or disclosures involving me, made in good faith and without malice by the Royal College.

Limitation of Liability:

The Royal College's liability for damages in connection with the conduct of the assessment whether arising in contract (including fundamental breach), tort (including negligence), or otherwise, even if the Royal College has been advised of the possibility of such damages, shall not exceed the amount of the assessment fee paid by the candidate. In no event shall the Royal College be liable for any indirect, incidental or consequential damages of any kind regardless of the cause and whether arising in contract (including fundamental breach), tort (including negligence), or otherwise, even if the Royal College has been advised of the possibility of such damages and release:

By providing my signature, I, the above-named physician, hereby acknowledge and agree to the Terms and Conditions listed above and consent to the disclosure of my personal information in accordance with those Terms and Conditions.

Applicant name (printed):

Applicant signature:

Date:

Witness name (printed):

Witness signature:

Date:

## SPECIALIST TRAINING INFORMATION

- Please provide an overview of the specialty training you have completed
- If possible, provide a single Program Director that can attest to all periods of specialty training
- Please ensure your Program Director is willing and able to provide an attestation of your training and are aware they will be contacted by the Royal College.
- Attach a separate document with your specialist training information if additional room is required
- Attached a separate document which details information about the specific rotations you completed during the specialist training outlined below (i.e. letters, training summary)

Start date:	End date:
Position:	Location:
Program Director name:	
Program Director email address:	

Start date:	End date:
Position:	Location:
Program Director name:	
Program Director email address:	

Start date:	End date:
Position:	Location:
Program Director name:	
Program Director email address:	

Start date:	End date:
Position:	Location:
Program Director name:	
Program Director email address:	

Please indicate your end-of-training date:

Did you have any interruptions or delays in your training? If yes, please complete the table below:		
Start date	End date	Type of leave/description

Did you focus on a particular subspecialty in your final year(s) of training? If yes, please complete the table below:

Start date	End date	Subspecialty

Program Director name:

Program Director email address:

Have you ever had your license or certification revoked by any medical authority and/or been subject to disciplinary action of any kind by such an authority? If yes, please explain.

Do you require any exam accommodations? Please see the Royal College website for instructions and additional information on [exam accommodations](#).

**Definition of a scope of practice:**

1. Every physician's scope of practice is unique
2. A physician's scope of practice is determined by the patients the physician cares for, the procedures performed, the treatment provided, and the practice environment
3. A physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgement, which are developed through training and experiences in that scope of practice

Name of applicant

1) Please describe your current scope of practice as it relates to the discipline of Medical Microbiology over the past two years in Canada.  
*e.g. clinical laboratory-based diagnostics, infection control, infectious diseases, antimicrobial stewardship?*

2) Please describe your current scope of practice as it relates to the discipline of Medical Microbiology over the past five years.  
*e.g. clinical laboratory-based diagnostics, infection control, infectious diseases, antimicrobial stewardship?*



4) In the chart below, please indicate in which location you see patients, the number of cases/patients seen, and the number of hours spent in clinical service during a *typical work week*:

Practice Settings	# cases/patients seen per week	# of hours spent in clinical/laboratory service per week
<b>A. OFFICE PRACTICE</b>		
a. Private office		
b. Walk-in clinic; after hours clinic; urgent care setting ( <i>e.g. generally no appointments; generally episodic care; non-static patient base</i> )		
c. Other (please specify)		
<b>B. HOSPITAL</b>		
a. Community hospital		
b. Academic/teaching hospital		
c. On-call hours per week		
d. Other (please specify)		

5) In the chart below, please indicate whether or not you are involved with each activity, number of hours per week, and what level of responsibility you have.

“Medical Microbiology is the branch of medicine concerned with the diagnosis, treatment, and prevention of infectious diseases”

Activity	Yes/No	Hours per week	Level of responsibility (LOW/HIGH)	
			Low – your results reviewed by someone supervising	High – your results constitute the report to the clinician
<b>Microbiology Laboratory</b>				
a. Scientific development			<input type="checkbox"/> Low	<input type="checkbox"/> High
b. Administration			<input type="checkbox"/> Low	<input type="checkbox"/> High
c. Clinical direction			<input type="checkbox"/> Low	<input type="checkbox"/> High
d. Use of a microscope for morphologic assessment of microorganisms			<input type="checkbox"/> Low	<input type="checkbox"/> High
e. Analyze microbiologic data and correlate it to clinical information			<input type="checkbox"/> Low	<input type="checkbox"/> High
f. Develop, adhere to, and review quality management data			<input type="checkbox"/> Low	<input type="checkbox"/> High
g. Review and supervise bench level tests available and develop test algorithms			<input type="checkbox"/> Low	<input type="checkbox"/> High
h. Review and report critical results			<input type="checkbox"/> Low	<input type="checkbox"/> High
i. Validation/verification of instrumental/methods			<input type="checkbox"/> Low	<input type="checkbox"/> High
j. General advice on microbiological testing, interpretation, guidance			<input type="checkbox"/> Low	<input type="checkbox"/> High
k. Other (please specify)			<input type="checkbox"/> Low	<input type="checkbox"/> High



Activity	Yes/No	Hours per week	Level of responsibility (LOW/HIGH) Low – your results reviewed by someone supervising High – your results constitute the report to the clinician	
<b>Clinical consultations:</b> <ul style="list-style-type: none"> <li>- Direct patient care includes taking history and physical</li> <li>- Indirect patient care includes discussion of a specific patient with the most responsible physician</li> </ul>				
a. In-patient consultations			<input type="checkbox"/> Low	<input type="checkbox"/> High
b. Out-patient consultations			<input type="checkbox"/> Low	<input type="checkbox"/> High
c. Consultations on testing for infectious diseases			<input type="checkbox"/> Low	<input type="checkbox"/> High
d. Consultations on diagnosis of infectious diseases			<input type="checkbox"/> Low	<input type="checkbox"/> High
e. Consultations on treatment of infectious diseases			<input type="checkbox"/> Low	<input type="checkbox"/> High
f. Consultations on infection prevention and control			<input type="checkbox"/> Low	<input type="checkbox"/> High
g. Consultations on antibiotic stewardship			<input type="checkbox"/> Low	<input type="checkbox"/> High
h. Other (please specify)			<input type="checkbox"/> Low	<input type="checkbox"/> High
<b>Teaching</b>				
a. Teaching of medical students			<input type="checkbox"/> Low	<input type="checkbox"/> High
b. Teaching of residents			<input type="checkbox"/> Low	<input type="checkbox"/> High
c. Education on general laboratory issues to clients, staff and other health care professionals			<input type="checkbox"/> Low	<input type="checkbox"/> High
d. Other teaching			<input type="checkbox"/> Low	<input type="checkbox"/> High

Activity	Yes/No	Hours per week	Level of responsibility (LOW/HIGH)	
			Low – your results reviewed by someone supervising	High – your results constitute the report to the clinician
<b>Research</b>				
a. Laboratory based research and development			<input type="checkbox"/> Low	<input type="checkbox"/> High
b. Evaluation and implementation of new technology for laboratory operations			<input type="checkbox"/> Low	<input type="checkbox"/> High
c. Other			<input type="checkbox"/> Low	<input type="checkbox"/> High
<b>Public Health</b>				
a. Epidemiology of communicable diseases			<input type="checkbox"/> Low	<input type="checkbox"/> High
b. Provision of advice/assistance			<input type="checkbox"/> Low	<input type="checkbox"/> High
c. Other			<input type="checkbox"/> Low	<input type="checkbox"/> High
<b>Other</b>				
a. Infection prevention and control medical direction?			<input type="checkbox"/> Low	<input type="checkbox"/> High
b. Antibiotic stewardship medical direction?			<input type="checkbox"/> Low	<input type="checkbox"/> High
c. Other (please specify)			<input type="checkbox"/> Low	<input type="checkbox"/> High

6) In the community in which you work, do you have:

a. Access to other laboratory specialists for referral or consultation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Access to other reference laboratories for consultation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Regular contact and interaction with Medical Microbiologists?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Regular contact and interaction with Infectious Diseases specialists?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7) If your past practice of Medical Microbiology during the past 10 years differs from your last year of scope of practice, please provide information to exemplify this (*or attach a current CV*)

8) Please list a minimum of 10 of the most common clinical consultations/laboratory consultations/infection control consultations/antibiotic stewardship and public health, that you *currently* see/perform in your practice.

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## CONTACT DETAILS FOR YOUR CURRENT CHIEF OF STAFF/SUPERVISOR

For those currently practicing in Canada.

*Your Chief of Staff/Supervisor will be asked to verify your submitted scope of practice and practice competencies. Please provide the contact information for your Chief of Staff/Supervisor.*

Surname:

Given name:

Middle name:

Street number and name:

Apt number:

City:

Province:

Postal code:

Phone:

Email:

*Please note: The information provided is subject to verification by the Royal College*