ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

Practice Eligibility Route

Pediatrics

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
- 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.

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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:

☐	I have between 3 and 5 years of practice as an independent specialist **or** I have more than 5 years of practice as an independent specialist, but **do not have** the final 2 years of practice in a current and continuous practice location in Canada
☐	I have more than 5 years of practice as an independent specialist, **with the** final 2 years of practice in a current and continuous practice location in Canada.

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REQUIRED DOCUMENTATION

Please submit the following documents to the Royal College with your application:	
☐	An up-to-date CV which includes the following information: • A summary of your practice and training to date • An explanation of any gaps in training or practice longer than three (3) consecutive months
☐	A copy of your currently medical license to practice *(if currently practicing in Canada)*
☐	A certificate of professional standing from your current Medical Regulatory Authority *(if currently practicing in Canada)* **This certificate must be ordered by you and sent to the Royal College directly from the MRA.**
☐	Details of training rotations completed to date in your specialty (e.g. area of rotation and time spent in this area)
☐	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.*	
☐	A copy of your medical degree (e.g. MD, MBBS)
☐	Specialty certificate/diploma received from jurisdiction of training showing eligibility to practice as an independent specialist
☐	Specialist licensure for all jurisdictions that you currently hold or have held a license to practice in your specialty
☐	Certificate of professional standing from your current practice location *(if outside Canada)*
☐	Internship document
☐	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) **Note: if you trained in a number of location and institutions, please submit documentation for all periods of training.**

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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

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PERSONAL DETAILS

Identification

RC ID (if applicable):	Gender: ☐ Male ☐ Female ☐ Other
Surname:	Date of birth *(DD/MM/YY)*:
Given name:	Middle name:

Contact information

☐ Home address ☐ Business address	Apartment number:	
Street number and name:		
City:	Province:	Postal code:
☐ Home ☐ Business ☐ Cell Phone:	☐ Home ☐ Business Email:	

Medical Graduation Diploma

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

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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:	

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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.

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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.

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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:

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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:	

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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

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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.

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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) How would you best describe your practice (e.g. general pediatric, general pediatrics with a particular focus – such as child abuse and neglect; palliative care; subspecialty pediatrics – naming the subspecialty, such as Neonatology, Cardiology, etc.)

2) Do you consider yourself to work part time? If so, how many hours per week do you work?

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3) In the chart below, please indicate in which location you see patients, the number of patients seen, and the number of hours spent in direct patient contact during a *typical month of work:*		
Practice Settings	**# patients seen per month**	**# of hours spent in direct patient contact per month**
A. AMBULATORY		
a. Private office		
b. Community health clinic		
c. Hospital out-patient clinic – general pediatrics		
d. Hospital out-patient clinic – specialized clinic – describe:		
e. Walk-in clinic; after hours clinic		
f. Emergency department – frontline		
g. Emergency department – on consultation only		
h. Other – describe:		
B. IN-PATIENT		
▪ Community general hospital		
Pediatrics ward		
Attending physician		
Consulting physician		
Attendance in delivery room		
Well newborn care		
Newborns seen only in consultation		
Other - describe:		

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Practice Settings	# patients seen per month	# of hours spent in direct patient contact per month
▪ Academic/teaching hospital		
Clinical teaching unit (CTU) as attending physician		
Non-CTU ward as attending physician		
Consultant for patients hospitalized under the care		
Neonatal intensive care unit		
Other newborn care - describe:		
▪ University teaching hospital		
Pediatric intensive care unit		
Long-term care or residential facility; hospice		

C. In which, if any, of these settings do you provide direct supervision to trainees (medical students, residents, fellows) while providing patient care?

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4) In a typical week, please estimate the percentage of your patient visits for whom the primary reason for the visit is one of the following (please note that the TOTAL SHOULD EQUAL 100%)	
Category	% of patient visits
A. **New presentations/acute condition management:** *New patients or known patients with new complaints or conditions requiring the formulation of a diagnosis in an office or practice setting*	
Patients seen for primary care	
Patients seen in consultation	
B. **Follow-up of patients seen in consultation**	
Patients seen for primary care	
Patients seen in consultation	
C. **Management of patients with ongoing/chronic conditions:** *Patients with chronic conditions requiring long-term monitoring*	
D. **Continuity of care with other specialists:** *Patients receiving active treatment from other medical specialists who you are monitoring*	
E. **Continuity of care with allied health care professionals:** *Patients seen in collaboration with or at the request of allied health care professionals*	
F. **Emergency management:** *Patients to whom you provide care in the emergency department or an acute care clinic*	
G. **Other:** *please describe*	

5) Describe the community in which you work, especially the way in which medical services are organized, collaboration with peers and other allied health staff and multidisciplinary teams.

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6) In the setting in which you practice, do you have the following:		
a. Access to basic laboratory services? *e.g. hemoglobin, urine, blood glucose analyses, etc.*	☐ Yes	☐ No
b. Access to advanced laboratory services? *e.g. blood gases, EEG, etc.*	☐ Yes	☐ No
c. Access to basic radiological services	☐ Yes	☐ No
d. Access to CT or MRI?	☐ Yes	☐ No
e. Access to other specialists for referral or consultation? *By phone or telemedicine only?* *In person?*	☐ Yes	☐ No
f. Regular contact and interaction with physicians in the same discipline in your community?	☐ Yes	☐ No

7) Do you provide on-call services (outside of regular working hours) for the patients for whom you provide care? Please describe how this is organized (e.g. frequency, duration, in-house, etc.)

8) Please describe the number of the following procedures that you have performed in the last three months:	
Procedure	Number
a. Newborn resuscitation including airway management and umbilical venous catheterization	
b. Cardiopulmonary resuscitation beyond the newborn period	
c. Obtaining macro blood draws	
d. Placing an intravenous	
e. Placement of an intraosseous needle	
f. Lumbar puncture	
g. Urinary catheterization or supra-pubic aspiration	
h. Placement of a gastric tube (naso or oro-gastric)	
i. Simple wound closure	
j. Needle thoracentesis and/or chest tube placement	
k. Sub-cutaneous, intra-dermal and/or intra-muscular injections	

9) Which of the following medications or treatments have you prescribed in the last three months?		
a. Oral antibiotics/antimicrobials	☐ Yes	☐ No
b. Intravenous/intramuscular antibiotics/antimicrobials	☐ Yes	☐ No
c. Enteral nutrition (nasogastric or gastrostomy tube feeding)	☐ Yes	☐ No
d. Systemic corticosteroids	☐ Yes	☐ No
e. Anti-epileptic drugs	☐ Yes	☐ No
f. Inhaled bronchodilators	☐ Yes	☐ No
g. Inhaled corticosteroids	☐ Yes	☐ No
h. Oral contraceptives	☐ Yes	☐ No

i. Insulin	☐ Yes	☐ No
j. Medications for attention deficit disorder	☐ Yes	☐ No
k. SSRIs and/or atypical antipsychotics	☐ Yes	☐ No
l. Sedative or narcotic medication	☐ Yes	☐ No

10) Please list a minimum of 10 of the most common conditions/diseases that you currently see in your practice, and indicate the approximate percentage of your workload each represents.

	Common conditions/diseases	% of workload
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

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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