このページは、御記載不要です

IMPORTANT

80 COLLEGE STREET, TORONTO, CANADA M5G 2E2

APPLICANT:

READ INSTRUCTIONS CAREFULLY!

DO NOT SEND INCOMPLETE FORM BACK TO THIS COLLEGE.

IT IS YOUR RESPONSIBILITY TO HAVE THIS FORM COMPLETED BY ALL MEDICAL LICENSING AUTHORITIES WHERE YOU HAVE BEEN REGISTERED.

INFORMATION PROVIDED ON THIS FORM IS VALID FOR SIX MONTHS ONLY. UPDATED INFORMATION WILL BE REQUIRED IF YOUR CERTIFICATE OF REGISTRATION IS NOT ISSUED WITHIN THAT PERIOD.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

FAX: (416) 961-3330
TOLL FREE: (800) 268-7096
TEL: (416) 967-2600

CONSENT FOR RELEASE OF INFORMATION TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- This section to be completed by the Applicant - このセクションは、申請者が記入する。

To the Medical Licensing Authority in: Japan 日本医師免許発行機関 御中
(province, state, territory or country)

I am applying for a certificate of registration to practise medicine in the province of Ontario, Canada, and before my application can be assessed, information relating to my qualifications and medical practice activities in your jurisdiction is required. 私はオンタリオ州で医療を行うための登録申請中です。そのためには、日本における私の資格と、行っていた医療に関する情報が必要です。

I hereby authorize your releasing to the College of Physicians and Surgeons of Ontario all information requested below and any other information respecting me which you deem relevant to my present application for a certificate of registration to practise medicine in Ontario, Canada.
私は、この登録に関して、下記の必要な情報全てをあなたがオンタリオ州内科医外科医協会に公開することを認めます。

I request the completed form and any appended information to be forwarded directly to:
私は、完成したこの用紙と添付された全ての情報が、下記の住所に直接転送されることを要請します。

The College of Physicians and Surgeons of Ontario
Registration Department
80 College Street
Toronto, Ontario, Canada
M5G 2E2

I understand you may require a fee for this service.
私は、このサービスに関してあなたが費用を要求するかもしれないことを了解します。

申請者の氏名
Full Name of Applicant (Print or Type)

医籍登録番号
Licence Number

申請者のサイン
Signature of Applicant

サインを行った日付（西暦）
Date

申請者の住所
Applicant's Address

*Note to the Applicant: A completed form is required from the medical licensing authority in every jurisdiction where you have practised medicine, postgraduate training appointments included. You may photocopy this form if you require additional copies.

このページの内容の御確認をお願いいたします

- This section to be completed by the Medical Licensing Authority -

このセクションは、医師免許発行機関（註：日本の専門医資格については各学会）が記入する。

1. This is to verify that, （下記の者が）～をここに証明する。

Dr. _____ ←申請者の氏名がローマ字表記で入る。
Full Name of Applicant

a) Graduated From: _____ 厚生労働省が記載しますので、空白で結構です。
卒業した医学部 *Name of Medical School*

b) Has been issued the following licence(s) by this medical licensing authority:
この機関による医師免許を発行されたこと（を証明する）。

Type of Licence	Licence Number	Date Issued	Date Expired/Cancelled
この部分は、厚生労働省に記載を別にお願いしていますので、空白でお願いいたします。			

c) Has the following specialty qualification(s) which is recognized by this medical licensing authority: この機関に認められた以下の専門医資格を有すること（を証明する）。

Specialty	Granted By	Date
Pediatrics	Japan Pediatric Society	
専門領域名（小児科）	認定学会名（日本小児科学会）	認定年月日（西暦）

d) Undertook the following postgraduate training appointment(s) in the jurisdiction governed by this medical licensing authority: この機関の管轄する地域において、以下の卒後研修を受けたこと（を証明する）。

Type of Program	Hospital/University	From/To
Pediatrics	ABC Hospital	
Pediatrics	XYZ Hospital	
研修プログラム名	研修施設名	研修期間（西暦）

このページの御記載をお願いいたします

2. Has the above-named physician ever been the subject of an inquiry or an investigation by this licensing authority involving an allegation of professional misconduct, incompetence, incapacitation or any like allegation?

Yes ☐ No ☐

3. Is the above-named physician currently the subject of an inquiry or investigation by this licensing authority involving an allegation of professional misconduct, incompetence, incapacitation or any like allegation?

Yes ☐ No ☐

4. Does the above-named physician appear in the records of this licensing authority as having been subject to reduced or cancelled privileges by a board of governors of a hospital due to incompetence, negligence, incapacitation or any form of professional misconduct?

Yes ☐ No ☐

5. Have there ever been any disciplinary or fitness to practise findings, or any like findings, made by this licensing authority against the above-named physician?

Yes ☐ No ☐

ここは、厚生労働省が記載しますので、御記載不要です

If "yes" has been answered to question 2,3,4 or 5 please provide all relevant information and documentation.

専門医認定機関の代表者の名前と役職（楷書）

Name and Title of Medical Licensing Authority Official

専門医認定機関名（日本小児科学会）

Japan Pediatric Society

Name of Medical Licensing Authority

専門医認定機関の代表者の署名（サイン）

Signature of Medical Licensing Authority Official

署名した日付（西暦）

Date

住所と、E-mailアドレス

Mailing Address & E-Mail Address

電話番号

Telephone Number

ファックス番号

Fax Number

専門医認定機関の印、またはエンボス

Seal or Stamp of Medical Licensing Authority to be Affixed Here

*Note to the Licensing Authority: You may fax the completed form to the Registration Department, College of Physicians and Surgeons of Ontario. Please ensure the original form is posted promptly.