

Independent Clinical Practice Application and Practice Plan

Residents applying for independent clinical practice for the first time must submit to the Postgraduate Medical Education Office, in addition to this form, the following:

- Independent Clinical Practice Application and Practice Plan
- Copy of CFPC/ RCPSC certification
- Proof of LMCC
- Proof of CMPA type of work code
- Copy of College of Physicians and Surgeons of Saskatchewan (CPSS) license

For renewal of independent clinical practice, resident should only submit this form.

Please send all documents and required information via email to the following: pgme.moonlighting@usask.ca

Resident is responsible for obtaining the appropriate license; reporting the license number to CMPA; obtaining appropriate approval/privileges with the health authority; and reporting independent clinical practice activities monthly to the PGME Office.

SECTION 1: RESIDENT INFORMATION

Name:	
Address:	
Program:	
Training Year:	

SECTION 2: INDEPENDENT CLINICAL PRACTICE INFORMATION

Name of Service	
Location of service: (Name of hospital/clinic and city)	

Job Description:		
Dates of approval: (Practice Plan valid until Nov 30)	Anticipated Start Date:	End date (if not November 30)

SECTION 3: APPROVALS AND SIGNATURES

I have reviewed the PGME Moonlighting and Independent Clinical Practice policy and accept the terms and limitations of this practice plan. I acknowledge that any change requires a revised practice plan and new approval.

I acknowledge and accept the terms of the PGME Moonlighting and Independent Clinical Practice policy, and RDOS Collective agreement regarding the maximum hours and limitations on work periods.

I agree that I will take responsibility of ensuring that all independent clinical practice activities are reported monthly to the PGME Office.

Resident Name:			
Signature:		Date:	

I have reviewed this application and practice plan. I am satisfied that undertaking such independent clinical practice is not anticipated to interfere with this resident's education.

Program Director:			
Signature:		Date:	

I have reviewed this application practice plan and approve this submission based on the recommendation by the Program Director.

Associate Dean, PGME:			
Signature:		Date:	