Newfoundland and Labrador Health Services

Physician Signing Bonus Program

APPLICANT INFORMATION

Surname:_____ Given Name:_____ Initial:_____

Date of Birth (DD/MM/YYYY):_____

Current Mailing Address:_____

Telephone: _____ Email:_____

PRACTICE INFORMATION

Region:_____

Facility:_____

Division/Department:_____

Physician Specialty:_____

Practice Start Date (DD/MM/YYYY):_____

CONFIRMATION OF PREVIOUS FUNDING

Has the applicant previously received funding under any other program offered by the Department of Health and Community Services (i.e. Undergraduate Medical Student Bursary, Medical Resident Bursary Program, Family Practice Programs)?

☐ Yes ☐ No

If yes, please provide details and amounts:

DECLARATION BY APPLICANT

I certify that all information given on this application is complete and true to the best of my knowledge.

I acknowledge that the Department of Health and Community Services is collecting the information contained in and included with this form for the purposes of considering and approving my application for funding under the Physician Signing Bonus Program, which is designed to attract and retain new, qualified physicians to provide health care services in the Province of Newfoundland and Labrador. I authorize the Department to collect my personal information and to use and disclose such information to other parties as it considers necessary for the purposes of considering and approving this application and assessing the efficacy of this program.

I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate repayment of current funding and disqualification from receiving future incentives. The Department of Health and Community Services has my consent to the collection, use and disclosure of my personal information in accordance with the ***Access to Information and Protection of Privacy Act, 2015****.*

Applicant Signature:_____ Date:_____

HEALTH AUTHORITY APPROVAL

Newfoundland and Labrador Health Services confirms that the applicant has accepted a full-time position to practice medicine with the health service in the province.

VP Medicine (or designate):_____ Date:_____

COMPLETED APPLICATIONS CAN BE RETURNED VIA MAIL OR EMAIL TO:

Medical Services Division
Department of Health and Community Services
1st Floor, West Block, Confederation Building
P.O. Box 8700, St. John's, NL A1B 4J6
MedServicesPrograms@gov.nl.ca