



FAMILY PRACTICE RENEWAL PROGRAM

Shalloway Family Practice Network Inc. ("Shalloway FPN") Membership Application

Instructions: Please print, complete, and sign below. You may submit directly to your Board Chair, Dr. Jared Butler, or scan and submit by email to fprp@nlma.nl.ca.

Physician name: _____

Practice name and location: _____

Phone number: _____

Email address: _____

Date of membership request: _____

Shalloway FPN Membership Categories (Please check applicable category.)

YOU ARE APPLYING TO BE A **GENERAL MEMBER** OF SHALLOWAY FPN. AS SUCH, YOU CONFIRM THAT THE FOLLOWING STATED CRITERIA IS TRUE AND ACCURATE:

- a. *You are a practicing General Practitioner who delivers the majority of your services in the defined Geographic Area whether on a Sessional, Fee-For-Service, Salaried or other basis, and whether delivering full service, specialized services (e.g. obstetrical, ER, hospitalists) or services at a walk-in clinic; and, you are licensed and in good standing with the College of Physicians and Surgeons of Newfoundland and Labrador.*

YOU ARE APPLYING TO BE AN **ASSOCIATE MEMBER** OF SHALLOWAY FPN. AS SUCH, YOU CONFIRM THAT THE FOLLOWING STATED CRITERIA IS TRUE AND ACCURATE:

- b. *You are a Medical Resident holding a full or educational license, practicing in the Geographic Area and enrolled in a family physician residency program in the Province of Newfoundland and Labrador; or, you are a retired General Practitioner in good standing with the College of Physicians and Surgeons of Newfoundland and Labrador.*

Physician signature: _____

Date: _____

By signing this form, the Board Chair indicates acceptance of this application, by the Shalloway FPN Board, for membership as indicated above, and as of the date noted below.

Board Approval: _____

Date: _____

Family Practice Renewal Program

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