ALBERTA MEDICAL ASSOCIATION

Patients First®

Eligibility Status Form

I acknowledge that to be eligible for the Continuing Medical Education, Medical Liability Reimbursement and Parental Leave Program(s), I must meet certain eligibility requirements.

Name: _____

First Middle Last

AMA #: _____ Practitioner's ID #: _____

To satisfy these requirements, I am a regulated member of the College of Physicians and Surgeons of Alberta, who holds a practice permit issued under the Alberta Care Health Professions Act (excluding physicians on the postgraduate register unless the postgraduate trainee is registered as a Physician extender) and have:

(Please select all those applicable from the list below):

- ☐ Received payment from the Physician Services Budget for billings (Insured Services listed in the Schedule of Medical Benefits) to Alberta Health.
- ☐ Received payment from the Physician Services Budget for Insured Services through an Alternative Relationship Plan.
- ☐ Received payment from Alberta Health Services for Insured Services or for providing laboratory services.
- ☐ Provided Locum Services.

I have satisfied the criteria declared above for the period:

- ☐ On a continuous and ongoing basis beginning _____ , 20 ___.
  (month/day)
- ☐ For the period beginning _____ 20___ and ending _____ , 20 ___.
  (month/day) (month/day)

I acknowledge that if my status changes, I should notify the Alberta Medical Association (AMA) immediately, and that in the event I receive benefits for a period of time where I did not meet the criteria above, I will be required to return the payment to the AMA.

_____ _____

(Signature of Declarant) (Date)

Please return the completed form to the AMA by email, fax or mail.

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