Medical Professional Corporation FORM "A"

Application for Issuance of a Certificate and Permit by a Professional Corporation

This is: ☐ an application for registration of a new Professional Corporation.
-OR-
☐ additions or changes to an existing corporation or reinstating a previously registered corporation (provide certificate #): _____

Note: *If there is insufficient space to provide the required information, please attach a separate sheet and type "See Attached Sheet" in the space provided. Fill out only pertinent sections that are changing.*

1. Name of Professional Corporation: _____

2. Address of the Professional Corporation: _____

_____

*Annual Renewal notices and permits will be emailed to the voting shareholders using the email provided in their physician profile with CPSS. **Please ensure that email addresses are kept up to date.** You can update your email address by sending an email to cpssinfo@cps.sk.ca with your old address and new address.

(New): we only require the class of shares to be provided and no longer need you to report on the number of shares.

3. List below all holders of **voting** shares in the Corporation:

Name	Address	CPSS Licence #	Class of Shares

4. Does any person other than those named in question 3 have any right to exercise voting rights with respect to the voting shares of the Professional Corporation? ☐ Yes ☐ No

If **"Yes",** provide full information relating to the arrangement:

_____

_____

_____

5. List below the individual holders of all **non-voting** shares of the Corporation:

Name	Name of member related to	Nature of relationship	**Class of Shares**

6. Are any shares of the Corporation owned by a Trust or Corporation? ☐ Yes ☐ No

Note: If any shares in the Corporation are owned by a trust or Corporation, then please **complete** a **Trust Information Sheet** or a **Corporation Information Sheet** for each Trust or Corporation, as found later in this package.

List below all **Trusts** or **Corporations** that hold shares in the Professional Corporation

Name of Trust or Corporation	**Class of Shares**

7. Does any person or corporation have any beneficial, equitable or other interest in any shares of the Professional Corporation other than disclosed in questions 3, 5 and 6? (Answer **"No"** if there are no such interests or if the only interest is security granted to a financial institution as security for a loan). ☐ Yes ☐ No

If the answer is **"Yes"**, attach a sheet providing full information relating to the beneficial or equitable interest.

8. List below the **directors** of the Professional Corporation (at least one director has to be listed)

Name of Director(s)

9. Do any persons practise medicine by, through, or in the name of the Professional Corporation other than persons listed in question 3 above? ☐ Yes ☐ No

If **"Yes"**, complete:

Name of such person	CPSS Licence #

10. Is the Professional Corporation in **good standing** pursuant to **The Business Corporation Act?** ☐ Yes ☐ No

If **"No"** attach a sheet describing the reasons why it is not in good standing.

11. Does each person who practises medicine by, through, or in the name of the Corporation, hold liability insurance that meets the requirements of the College bylaws? ☐ Yes ☐ No

List below all physicians who practise medicine by, through or in the name of the Corporation and details respecting their insurance coverage:

Name	CMPA policy # (*if CMPA member*)	Name and address of insurer and policy number if not a CMPA member	Liability coverage per occurrence if not a CMPA member

12. Do the articles of the Professional Corporation prevent it from carrying on any business or activities associated with the practice of medicine by any physician listed in question 3 or 11 above? ☐ Yes ☐ No
If **"Yes"** attach a sheet describing full details of the restrictions.

13. If this is an application for registration, **attach the Articles** of Incorporation for the Professional Corporation with the Certificate and Schedules attached.

The following certification must be signed by each physician who is listed in question 4 above.

I/We certify that:

1. Each Statement in this application is true;

2. Each person signing this declaration has read and is familiar with the provisions of **The Medical Profession Act, 1981** relating to professional incorporation and the bylaws of the College relating to professional incorporation and the bylaws of the College relating to professional liability coverage.

3. Each person undertakes that he/she will notify the College if she/he becomes aware that the Professional Corporation does not comply with the provisions of **The Medical Profession Act, 1981** relating to professional incorporation, or the bylaws of the College relating to professional incorporation; or if the Professional Corporation fails to comply with any terms or conditions contained in a permit.

Signature	Name	Date
Signature	Name	Date

*****A scanned, mailed, or faxed copy will be accepted as the original. Please fax to 306-912-7437.
Note: If emailed, we ask that you **do not send** the Credit Card Authorization form, to protect your personal information.

Corporation Information Sheet

*Only fill out if another corporation (holding company) is being added to the Medical Prof. Corp. under #6)

A separate corporation information sheet must be completed for each corporation that holds any legal or beneficial interest in the shares of a Professional Corporation.

1. Name of Corporation: _____

2. List below all holders of shares in the Corporation:

Name	Name of Member related to	Nature of Relationship

3. Does any person or Corporation have any beneficial, equitable, or other interest in any shares of the Corporation other than as disclosed in question 2? (Answer "No" if there are no such interests or if the only interest is security granted to a financial institution as security for a loan.) □ Yes □ No

   If the answer is "Yes", attach a sheet providing full information relating to the equitable or legal interest.

I/We certify that each statement in this document is true to the best of my/our knowledge, information and belief:

Signature	Name	Date
Signature	Name	Date

Trust Information Sheet

A separate Trust Information Sheet must be completed for each trust that holds any legal or beneficial interest in any shares of a Professional Corporation.

1. Name of Trust: _____
2. Name and address of Trustee: _____
3. Name and relationship of every beneficiary, or possible beneficiary, under the Trust:

Name	Name of Member with relationship to the beneficiary	Relationship

4. Does the trust permit any beneficial or contingent interest in the Trust for any person other than those persons named in question 3? ☐ Yes ☐ No

   If **"Yes"** either:

   a) ☐ a copy of the Trust Agreement is attached; or

   b) ☐ a copy of the Trust Agreement was previously filed with the College and the terms of the Trust have not been amended since the return was last filed;

5. Is any beneficial or contingent interest in the Trust subject to any agreement that could provide any benefit to a person not listed in question 3? (Answer **"No"** if there is no such agreement or if the only agreement is security granted to a financial institution as security for a loan.) ☐ Yes ☐ No

   If **"Yes"** either:

   a) ☐ full details of the agreement have previously been provided to the College, including a copy of the agreement, if the agreement is in writing.

   b) ☐ full details of the agreement are attached, including a copy of the agreement, if the agreement is in writing.

I/We certify that each statement in this document is true to the best of my/our knowledge, information and belief:

_____

Signature Name Date

_____

Signature Name Date

Credit Card Authorization Form

DATE *(mm/dd/yyyy)*: _____

CLIENT NAME (Please print)**:** _____

CONTACT INFORMATION (Address where receipt is to be sent)			
Street, PO BOX, APT#			
City/Town	Province/State	Postal Code/Zip Code	Country
Email address where receipt is to be sent:			

SERVICE/PRODUCT: ☒ Corporation Certificate and/or Permit Application

PAYMENT INFORMATION AND AUTHORIZATION

I, _____
(Cardholder's Name – Please Print)

authorize the College of Physicians and Surgeons of Saskatchewan to charge my credit card for the amount stated below.

Amount Authorized: $ _____

Cardholder Signature: _____
Please print and sign manually. Electronic signatures not accepted.

Name as it appears on card: _____

Credit Card Number: | | | | | | | | | | | | | | | |

Expiration Date: | | | | ☐ Visa/Visa Debit ☐ Mastercard/Mastercard Debit

FAX* OR MAIL THIS FORM TO:

**To protect your information we cannot accept authorization forms by email.*

Fax: (306) 912-7437

College of Physicians and Surgeons of Saskatchewan
101-2174 Airport Drive, Saskatoon, SK S7L 6M6