# Application Form

## Rural Physician Incentive Program (RPIP)

Please apply within the first 90 days of each year of practice.

**Applicant Information:**

Full Name: ___________________________ ______________________________ _____________________________
Last First Middle

Email Address: ____________________________________________ Phone Number: _________________________

Mailing Address: ___________________________________________________ Postal Code: ___________________

MINC number: ______________________________

**Education:**

Country of medical degree: __________________________________________________________________________

University of postgraduate medical education: ___________________________________________________________

Country of postgraduate medical education: _____________________________________________________________

Date of completion of postgraduate education: ___________________________

**Incentive:**

I am submitting an application for:

Year 1* - $10,000

Year 2 - $10,000

Year 3 - $12,000

Year 4 - $15,000

*Note: a new application for RPIP must be submitted each year.*

***First time applicants:**

☐ I have included a copy of my certificate of completion of residency/internship training with my application form.

**Community & Practice Information:**

| Rural/Remote Sask. Community | Start Date | End Date | Full-time/Part-time, Visiting, or Locum | Payment Modality (FFS, Shadow billing, contract) |
|---|---|---|---|---|
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**Clinic/Manager Contact Information:**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Disclosure – Check each clause to acknowledge each statement:**

Please apply within 90 days.  Adjudication of the RPIP will be made by saskdocs (a part of the Saskatchewan Health Authority).

___ I have read and understand the RPIP criteria as outlined in the Program Parameters.

I agree that my information may be shared with the Saskatchewan Medical Association (SMA), Saskatchewan Health Authority, Northern Medical Services, and Saskatchewan Ministry of Health officials to verify that I meet the eligibility criteria set out in the program parameters.

___ I acknowledge that if I have been a prior recipient of the SMA's Rural Practice Establishment Grant (RPEG) I will only be considered for years three (3) and four (4) of RPIP.

I agree that the Ministry of Health/Saskatchewan Health Authority (SHA) reserves the right to change, amend, modify, suspend, continue or terminate all or any part of the program, either in an individual case or in general, at any time without notice.

___ I agree that the Ministry of Health may release my fee-for-service and/or shadow billings to the SHA to confirm service volumes and full-time status.

Your application will be adjudicated by saskdocs after 12 months of service are complete to confirm that you have met the service criteria over the year. If you qualify, you may receive the incentive after the end of the 12 months service period.

I hereby certify that all information and statements made in this application are true and complete to the best of my knowledge and belief.

Signature of Applicant _______________________________________ Date: ___________________________________

Submit completed application to:

Email: info@saskdocs.ca or Fax: 306-933-5115