



**Application for Saskatchewan Health Authority**  
**Psychiatry Recruitment and Retention Incentive**

***Application Information***

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street address: \_\_\_\_\_ City/Town: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Specialty:**

- Psychiatry

**Community of Practice:**

- North Battleford
- Yorkton
- Swift Current
- Moose Jaw
- Prince Albert
- Weyburn
- Lloydminster

**Saskatchewan Practice History:**

| Community | Start Date | End Date | Full-time, part-time, or locum | Estimated FTE | Payment Modality (FFS /contract) |
|-----------|------------|----------|--------------------------------|---------------|----------------------------------|
|           |            |          |                                |               |                                  |
|           |            |          |                                |               |                                  |
|           |            |          |                                |               |                                  |

**Additional comments/anticipated LOAs:**

---

---

**Application Year:**

- Year 1 – \$40,000
- Year 2 – \$40,000
- Year 3 – \$20,000
- Year 4 – \$50,000
- Year 5 – \$50,000

*Please apply at the beginning of each year of practice. A new application must be submitted each year.*

**Have you received funding under any other program?** (e.g. SMA's Specialist Recruitment Incentive, etc.)

- Yes
- No

Specify: \_\_\_\_\_

**Disclosure**

- I have read and understand the eligibility criteria as outlined in the Program Parameters.
- I agree that my information may be shared with Saskatchewan Health Authority and Saskatchewan Ministry of Health officials to verify that I meet the eligibility criteria set out in the program parameters.
- I agree that the Ministry of Health/Saskatchewan Health Authority 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 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: \_\_\_\_\_

Email completed form to [physicianincentives@saskhealthauthority.ca](mailto:physicianincentives@saskhealthauthority.ca)