



1	Surname		Given Names		Male <input type="checkbox"/>	Date of Birth		
					Female <input type="checkbox"/>	Y	M	D
2	Mailing Address				Telephone			
					( )			
					Fax			
				( )				
Postal Code			Email					
3	Specialty				Date of Certification			Certification Body
					Y	M	D	

**BRIEF DISCRIPTION OF INTENDED TELEMEDICINE SERVICE**

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**In applying to provide telemedicine service into New Brunswick, I attest to the following:**

1. I am currently licensed in my home jurisdiction
2. I will maintain that license at all times while providing any telemedicine service
3. There are no restrictions on my license in my home jurisdiction which would preclude the intended telemedicine service
4. I have appropriate malpractice coverage, or other assistance, such as through the Canadian Medical Protective Association, to provide the intended telemedicine service
5. In providing the telemedicine service, I will make all reasonable efforts to comply with such statutes, regulations, rules, or policies which would apply to the service if it were provided in New Brunswick
6. As a precondition to providing this service, I will not require any New Brunswick patient to agree to any release regarding choice of laws or forum, should any legal action arise from the provision of this service
7. I accept the jurisdiction of the medical regulatory authority in my home province or territory to consider any complaints which may arise from the provision of this service

Date \_\_\_\_\_

Signature of applicant \_\_\_\_\_