Pre-screen Form

International Medical Graduates (IMGs) seeking to practise as family physicians in Saskatchewan are invited to complete this pre-screen form. **Do not complete an Application for Registration in physiciansapply.ca until you have been advised by SHRA** to do so, as the assessment fees are non-refundable.

IMPORTANT: DO NOT check "YES" unless you have completed the item AND HAVE RECEIVED YOUR PASS RESULTS as of the date you complete the Pre-screen form.

If you have completed the exam but not yet received your results, OR if you intend to complete the exam in future, PLEASE SELECT THE APPROPRIATE OPTION.

Once the Pre-screen form is approved by the Saskatchewan Healthcare Recruitment Agency (SHRA), CPSS will confirm the answers you have declared here were true as of the date approved.

ACKNOWLEDGEMENT: I acknowledge the importance of truthful and current responses on this pre-screen form. I acknowledge that if I answer "YES" when I either have not yet completed the item or have not yet received passing results, THIS WILL RESULT IN MY APPLICATION FOR LICENSURE BEING REJECTED BY THE CPSS. I acknowledge that this will require me to respond "YES" on any future application question asking whether I have ever had an application to a regulatory body for licensure refused and may result in possible disciplinary action for dishonesty in completing an attestation/declaration in the event I am ultimately licensed by the CPSS.

I ALSO ACKNOWLEDGE that if I answer "YES" when I either have not yet completed the item or have not yet received passing results, I will be required to start again at the Pre-screen stage, and I will lose any advantage I may have gained in the queue through providing incorrect or dishonest information on my initial Pre-screen.

I HAVE READ AND UNDERSTAND THE ABOVE, AND ATTEST that all information provided on this Pre-screen is correct as of the date submitted. If I have questions as I complete this Pre-screen, I acknowledge I can raise those with the SHRA or my own legal counsel.

Last Name(s):			
Given Name(s):			
Email Address:		**Date Submitted:**	

PLEASE COMPLETE THE FOLLOWING:

1. Have you successfully completed medical training and obtained a Medical Degree?	☐ Yes ☐ No
And	

2. Have you successfully completed a minimum 12 months of post-graduate training, internship or residency in Family Medicine? **And** **Have you practiced as the Most Responsible Physician for a minimum of 156 weeks (in person) under a licence for independent practice? See 2. Appended**	☐ Yes ☐ No
Or	
Have you successfully completed 24 months or longer of post-graduate training, internship or residency training in Family Medicine? **And** **Do you hold a licence for independent medical practice?**	☐ Yes ☐ No

[2] **Family Medicine practice refers to**: active independent practice, which means the physician has been practicing independently as the patient's Most Responsible Physician. This means the physician is authorized to diagnose, plan, implement, manage and follow up with plan for treatment for a patient as well as order medications and diagnostic procedures. Arrangements that do not qualify include volunteer positions if the physician is not the most responsible physician, assist work, observerships and preceptorships.

2. Currency of Practice
***Minimum 26 weeks of currency in the past three (3) years.**

Currency of practice requirements can be met by any combination of the following:

	Eligibility	Preferred Experience	Number of Weeks
Most Responsible Physician (MRP)	• **Family medicine practice** • **GP-Specialist: minimum 20 hours per week in family medicine practice**	• **Full scope family medicine**	**<Enter Weeks>**
Clinical Assistant / Associate Physician	• **Licensed in Canada** • **Isolated surgical assistant work does not qualify**	• **Hospitalist, emergency medicine, primary care**	**<Enter Weeks>**
Postgraduate Training	• **Clinical rotations**	• **Training in family medicine, anesthesia, emergency medicine, obstetrics & gynecology, pediatrics, surgery, internal medicine or psychiatry**	**<Enter Weeks>**

3. Medical Council of Canada Exam Passes		
MCCQE1 or MCCQE	☐ Yes	Date Passed: ***results have been issued and shared with CPSS at physiciansapply.ca**
	☐ In Progress	Anticipated date of results:
	☐ No, but intend to	Intended date to write Exam:
NAC OSCE	☐ Yes	Date Passed: ***results have been issued and shared with CPSS at physiciansapply.ca**
	☐ In Progress	Anticipated date of results:
	☐ No, but intend to	Intended date to write Exam:

4. English Language Proficiency (ELP)		
Examinations	**Passed within last 24 months of today's date?**	**Passed by exam date older than 24 months from today's date?** ***Please select A, B or C from list below**
***IELTS – Academic** Minimum of 7.0 in each component	☐ Yes ***results have been issued**	☐ Yes **AND** ☐ A or ☐B or ☐C
Or ***IELTS – Academic** Minimum of 7.0 in each component	☐ I Intend to write this exam Date Anticipated:	
***OET – Medicine** Minimum grade of B in all sections	☐ Yes ***results have been issued**	☐ Yes **AND** ☐ A or ☐B or ☐C
Or ***OET – Medicine** Minimum grade of B in all sections	☐ I intend to write this exam Date Anticipated:	
***CELPIP - General** Minimum grade of 9 in all sections	☐ Yes ***results have been issued**	☐ Yes **AND** ☐ A or ☐B or ☐C
Or ***CELPIP - General** Minimum grade of 9 in all sections	☐ I intend to write this exam Date Anticipated:	
	A. *Currently enrolled in postgraduate medical education in a Country where English is the language of instruction, and you used this exam to enter post graduate training. B. *Currently practising in English and used this exam to obtain licensure in that Country of practice. C. *Currently working in English-speaking environment	
OR		
Alternate Proof		
*Primary or secondary medical training outside of Canada in English within 5 years of application to the CPSS, in a country that has English as a first and native language or as verified by the Institution of Training. If the instruction was more than the 5 years designated, the Registrar may consider other proof, such as evidence they have worked in an English-speaking environment.	☐ Yes	
* Undergraduate medical education taken outside of Canada in English, within 5 years of application to the CPSS, in a country that has English as a first and native language or as verified by the Institution of Training. If the instruction was more than the 5 years designated, the Registrar may consider other proof, such as evidence they have worked in an English-speaking environment.	☐ Yes	
* Canadian returning to Canada, primary or secondary medical training outside of Canada in English as verified by institution	☐ Yes	
*Completed Fellowship, minimum of one year in length, within a country that has English as a first or native language, within 5 years of application to the CPSS, If the fellowship was more than the 5 years designated, the Registrar may consider other proof, such as evidence they have worked in an English-speaking environment.	☐ Yes	
*Completed Practice Ready Assessment in English, in Canada, within 5 years of consideration for licensure with CPSS	☐ Yes	
*Currently hold medical licence in any province or territory in Canada and practise primarily in English	☐ Yes	
*Other selection from CPSS' current English Language Proficiency policy	☐ Yes	

*Proof to be reviewed by the Registrar during the CPSS application review.

PLEASE CONFIRM RE: PHYSICIANSAPPLY.CA

5. **Physiciansapply.ca -** Verification of Medical Degree; Transcripts; Family Medicine postgraduate training/internship/residency "Sent for Source Verification" or "Passed".	☐ Yes
6. **Physiciansapply.ca -** Documents shared with *CPSS*: Medical Degree; Transcripts; Family Medicine postgraduate training/internship/residency; NAC OSCE exam and MCCQE1/MCCQE exam.	☐ Yes

CONSENT TO SHARE INFORMATION:

☐ Yes	I consent to share my pre-screen checklist with Saskatchewan Health Authority, Saskatchewan Healthcare Recruitment Agency/Health Careers Saskatchewan, Ministry of Health, the College of Physicians and Surgeons of Saskatchewan, SIPPA and/or the University of Saskatchewan, College of Medicine.

DISCLAIMER:

☐ Yes	I understand that the information from this Pre-Screen Checklist will be **confirmed** and used to determine if I meet eligibility requirements for licensure and/or the requirements of the SIPPA program to be selected into that program
☐ Yes	I understand that successful completion of this Pre-Screen Checklist does not guarantee that I will be offered a seat in the SIPPA program or awarded a medical licence in Saskatchewan.
☐ Yes	I understand SIPPA is a highly competitive program and there is no guarantee of selection
☐ Yes	**I have provided truthful, accurate and verifiable information on the pre-screen form, current as of the date completed, and I acknowledge that if it is not, this may result in a denial of consideration, dismissal and/or termination.**

Once you have completed the Pre-screen Form, please email it to info@saskhealthrecruitment.ca and upload a copy of your Curriculum Vitae (CV) into your Health Careers Saskatchewan (HCS) profile.

CONSENT FOR RELEASE OF INFORMATION

SASKATCHEWAN INTERNATIONAL PHYSICIAN PRACTICE ASSESSMENT (SIPPA) PROGRAM

*I, _____, the undersigned, am applying to the Saskatchewan International Physician Practice Assessment program (the "***SIPPA program***"). I consent to the release and sharing of information as detailed below.*

1. I understand and acknowledge that there are several partner organizations involved in the review of applications, the selection of candidates, and the operation of the SIPPA program.
2. I understand and acknowledge that these partner organizations (the "**SIPPA Partners**") include:
    a. the College of Physicians and Surgeons of Saskatchewan (the "**CPSS**");
    b. the College of Medicine, University of Saskatchewan (the "**CoM**");
    c. the SIPPA Medical Directors, faculty and staff (the "**SIPPA team**");
    d. the Saskatchewan Healthcare Recruitment Agency (the "**SHRA**");
    e. Health Careers Saskatchewan (formerly saskdocs) (the "**HCS**");
    f. the Saskatchewan Health Authority (the "**SHA**"); and
    g. the Saskatchewan Ministry of Health.
3. I understand and acknowledge that as part of my application to be considered as a candidate for the SIPPA program, I will be asked by one or more of the SIPPA Partners to provide documentation and information (the "**Submitted Information**").
4. I understand and acknowledge that in the course of assessing and processing my application, the SIPPA Partners may choose to request and gather additional information (the "**Third Party Information**") from organizations involved in credentialing, regulating or licensing physicians in Canada; or involved in assembling of physician information for the use of organizations that credential, regulate or license physicians in Canada; or organizations or bodies involved in the provision of medical education, and for that purpose some or all of the Submitted Information may be released to third parties.
5. I expressly consent to the release of Submitted Information for the purpose described in paragraph 4. For greater certainty, , I expressly consent to the release of my Submitted Information to physiciansapply.ca, the Application for Medical Registration in Canada, the Medical Council of Canada (the "**MCC**"), any medical regulatory authority in Canada, and any post-graduate medical education programs with which I have been enrolled.
6. In order to facilitate the review of my application to the SIPPA program, I understand and acknowledge that the SIPPA Partners share the Submitted Information and Third

Party Information rather than each requesting the same information from each applicant and applicable third party. I expressly consent to such sharing of the Submitted Information and Third Party Information between the SIPPA Partners, as may be required to assess and process my application to the SIPPA program.

7. If I am selected for the SIPPA program, I understand and acknowledge that the SIPPA Partners may share some or all of the Submitted Information and Third Party Information with physicians who are engaged to act as supervisors and/or assessors or otherwise participate in the operation of the SIPPA program. I expressly consent to such sharing of the Submitted Information and Third Party Information for the purpose of participating in the SIPPA program.

8. If I am selected for the SIPPA program, I understand and acknowledge that the physicians acting as supervisors and/or assessors will provide information to the SIPPA Partners (the "**Assessment Information**"). I expressly consent to such sharing of the Assessment Information.

9. I understand and acknowledge the reasons for the release and sharing of information as detailed above, and the risks and benefits associated with that. I expressly consent to the release and sharing of information as detailed above for the purpose of the consideration of my application to and, if selected, my progress within, the SIPPA program.

10. I understand and acknowledge that the SIPPA Partners may also use Submitted Information, Third Party Information and Assessment Information in a de-identified or aggregate manner for ongoing program development, quality process improvement, and for research purposes. I expressly consent to the use of the information in this format for these purposes.

11. I understand and acknowledge that each of the SIPPA Partners will comply with any and all laws which apply to it pertaining to the handling of personal information or personal health information contained within the Submitted Information, the Third Party Information, and the Assessment Information.

12. I understand and acknowledge that each of the SIPPA Partners will also comply with its individual organizational privacy policies with respect to its collection, use, disclosure, retention and protection of the Submitted Information, the Third Party Information, and the Assessment Information.

13. I understand and acknowledge that I may withdraw this consent at any time by notifying all the SIPPA Partners in writing. However, I understand and acknowledge that a withdrawal of consent can only apply to any sharing of information *after the date* I communicated the withdrawal in writing.

14. I understand and acknowledge that if I notify one or more of the SIPPA Partners (but not all) in writing that I have withdrawn my consent, then only those SIPPA Partners who

have received the notice are prevented from sharing information after it receives such notice.

15. I further understand and acknowledge that my withdrawal of consent may impact the processing of my application to the SIPPA program, as it may impact the ability of the SIPPA Partners to assess the Submitted Information.

Date: _____

Printed Name: _____

Signature: _____

Revised as of August 18, 2026