College of Physicians and Surgeons of Newfoundland and Labrador

Suite W100, 120 Torbay Road, St. John's, NL A1A 2G8
T. 709.726.8546 F. 709.726.4725 E. cpsnl@cpsnl.ca

Closure of Medical Practice and Extended Leave from Practice

PLEASE PRINT CLEARLY

Physician's name: _____ Licence no.: _____

Practice address to be closed: _____

_____

_____

Anticipated date of closure/leave: _____/_____/_____
Month Day Year

Anticipated date of re-opening: _____/_____/_____
(if applicable) Month Day Year

Location of patient records: _____

Mailing address / telephone number: _____

(for patient use) _____

_____

New mailing address / telephone number: _____

(College use only) _____

_____

_____

Email address: _____
(College use only)

Has another physician assumed care of your patients? Yes ☐ No ☐

If yes, please provide the physician's name: _____

I,_____, acknowledge that I have read the College's Practice Guideline
(Physician's signature)

entitled "Closure of Medical Practice and Extended Leave from Practice."

Date Submitted: _____/_____/_____
Month Day Year