ALBERTA MEDICAL ASSOCIATION

Patients First℠

Eligibility Status Form

I acknowledge that to be eligible for the Continuing Medical Education, Medical Liability Reimbursement, Parental Leave, Panel Management Support Program and Retention and Recruitment program(s), I must meet certain eligibility requirements.

Name: _____

First Middle Last

AMA #: _____ Practitioner's ID #: _____

To satisfy these requirements, I am a regulated member of the College of Physicians and Surgeons of Alberta (CPSA), entitled to receive payment of Benefits under the Alberta Health Care Insurance Plan (excluding Physicians who hold a provincial register postgraduate training license through the CPSA, unless the postgraduate trainee is registered as a Physician extender) pursuant to the Alberta Health Care Insurance Act and/or employed by or a party to a service agreement with a person under section 20.1 of the Act that enables the person to receive payment of Benefits in respect of Insured Medical Services provided by the Physician under the employment of service agreement, and have:

(Please select all those applicable from the list below):

1. Received payment from the Physician Services Budget for billings (Insured Services listed in the Schedule of Medical Benefits) to Alberta Health including:
   - ☐ Fee For Service Billing
   - ☐ Providing Locum Services

OR

2. Received compensation from a distinct payment arrangement including:
   - ☐ Alternative Relationship Plan
   - ☐ Providing Laboratory Services
   - ☐ Employed by or a party to a service agreement with a person under section 20.1 of the Act

I will satisfy the criteria declared above:

☐ On a continuous and ongoing basis beginning _____
(MM/DD/YYYY)

☐ Beginning _____ and Ending _____
(MM/DD/YYYY) (MM/DD/YYYY)

I acknowledge that if my status changes, I should notify the Alberta Medical Association (AMA) immediately, and that in the event I receive benefits for a period of time where I did not meet the criteria above, I will be required to return the payment to the AMA.

_____ _____
(Signature of Declarant) (Date)

Please return the completed form to the AMA by email, fax or mail. *Revised August 2024*

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