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Eligibility Status Form

Continuing Medical Education Reimbursement Program, Medical Liability Reimbursement Program, Retention Benefit Program

Name: _____
First Middle Last

AMA #: _____ Practitioner's ID #: _____

I acknowledge that to be eligible for the Continuing Medical Education, Medical Liability Reimbursement or Retention Benefit program(s), I must meet certain eligibility requirements.

To satisfy these requirements, I declare that for the period specified below, I have been a resident of Alberta and have: (please select all those applicable from the list below):

- ☐ Received payment from the Physician Services Budget for billings (Insured Services listed in the Schedule of Medical Benefits) to Alberta Health.
- ☐ Received payment from the Physician Services Budget for Insured Services through an Alternative Relationship Plan.
- ☐ Received payment from Alberta Health Services for Insured Services or for providing laboratory services.
- ☐ Provided Locum Services.

I have satisfied the criteria declared above for the period:

- ☐ On a continuous and ongoing basis beginning _____ , 20 ___.
(month/day)
- ☐ For the period beginning _____ 20___ and ending _____ , 20 ___.
(month/day) (month/day)

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 mail or by fax at 780.482.5445.

Revised June 2013