Declaration and Consent for Natural Persons as Group Physicians

To: **Ministry of Health and Long-Term Care (the "Ministry")**

And To: **Physician Clinical Teachers' Association (the "Physician Organization")**

And To: **Northern Teaching Hospitals Council (the "Hospital Organization")**

And To: **Northern Ontario School of Medicine ("NOSM")**

And To: **Ontario Medical Association (the "OMA")**

1. I am a Group Physician as that term is defined in the agreement entered into among the Physician Organization, the Hospital Organization, NOSM (collectively referred to as the **"Governance Organization"**), the Ministry and the OMA effective as of the 1st day of April, 2016, including all appendices and any amendments to the agreement (the **"Agreement"**).

2. Capitalized terms used, but not defined, in this Declaration and Consent have the same meanings as those terms have in the Agreement.

3. I have read and understand the Agreement.

4. I authorize the lead physician for the Physician Organization, as may be specified from time to time in Appendix "G" of the Agreement (or as may be designated in writing to all Parties in accordance with the Agreement), to sign the Agreement on my behalf.

5. In consideration of the remuneration I will receive from the Governance Organization:

    (a) I shall continue to be a Group Physician for as long as I provide Clinical Services and Academic Activities;

    (b) as a Group Physician, I am a member of the Physician Organization, and shall continue to be a member of the Physician Organization for as long as I provide Clinical Services and Academic Activities, and agree that the obligations of the Physician Organization under the Agreement are the obligations of the Group Physicians collectively;

    (c) I shall be bound by the terms and conditions of the Agreement as a Group Physician; and

    (d) I authorize the Ministry to disclose to the OMA my name and the fact that I am a Group Physician under the Agreement.

6. I agree that section 5(d) of this Declaration and Consent shall survive the termination of the Agreement.

Date: _____

Name of physician: _____

Signature of physician: _____

Name of witness: _____

Signature of witness: _____

OHIP Number
(billing number): _____

College Registration Number: _____