

COUNTY *of* ANNAPOLIS

NATURALLY ROOTED

Municipality of the County of Annapolis **Medical Recruitment Financial Assistance Program**

This program was established to encourage physicians and nurse practitioners to set up a practice in the County of Annapolis

Who can apply and what are the requirements?

- Any physician or nurse practitioner may apply for financial assistance within six (6) months of setting up a full-time or part-time practice in any community within Annapolis County.
- To be eligible, the physician or nurse practitioner must sign a minimum three-year return of service agreement with the province and a copy of proof must be provided with this application.
- Funding under this program may be provided in addition to any incentive funding provided by the province or any other government agency or non-profit organization.
- The Municipality may choose to provide the financial support directly, or indirectly to a community based non-profit society or another government entity.
- Financial assistance may be provided at the sole discretion of the Municipality in the amount of \$10,000 for eligible full-time medical practitioners and up to \$5,000 for part-time medical practitioners upon a recommendation from the Physician Recruitment and Retention Committee.
- In no case shall any applicant receive funding more than once.

How is the funding provided?

The Municipality will provide any approved funding in two installments, one half upon approval of the application, and the second installment one year later.

How do I submit an application?

Submit application forms and all required documentation to the Annapolis County Physician Recruitment and Retention Committee. Incomplete applications will not be considered .

Municipality of the County of Annapolis
ATTN: Physician Recruitment and Retention Committee
c/o Sarah Kucharski, Deputy CAO
PO Box 100, 752 St. George Street, Annapolis Royal, NS
Email: info@annapoliscounty.ca Fax: 902-532-2096

Municipality of the County of Annapolis
Medical Recruitment Financial Assistance Program
Application Form

Name of Applicant	
Contact person	Position in organization
Mailing address	Postal code
Phone / Cell	Email
Name of medical professional	<input type="checkbox"/> Doctor <input type="checkbox"/> Nurse Practitioner
Gender	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
Location of practice	Date established practice at this location
Date of signed offer and return of service agreement <i>(please attach copy of proof)</i>	Amount requested
PLEASE NOTE: Personal information on such as salary, date of birth, license / identification #'s may be redacted on the offer and return of service documents to protect privacy of the individual	
Date	Signature
I certify that the information supplied in this application is, to the best of my knowledge, exact and complete, and that the grant request was approved by the organization I represent.	
<i>Save the completed form and email a copy to: info@annapoliscounty.ca</i>	