SASKATCHEWAN MEDICAL ASSOCIATION
201-2174 Airport Drive • Saskatoon, SK • S7L 6M6
p. 306 244 2196 • f. 306 653 1631 • w. www.sma.sk.ca

Application Form for After-Hours Urgent Care Clinic Program

Purpose: To provide a semi-annual lump sum payment to the SMA and Ministry approved fee-for-service clinics that provide after-hours urgent care services and meet the eligibility criteria listed below.

Applicant Information:

Clinic Name: _____ Clinic Number: _____

Address: _____ Phone: _____

_____ City: _____

Email: _____

A Self-declaration of Onsite Urgent Care Capabilities – All criteria below must be met for eligibility	Initials
✓ The clinic advertises and operationally offers extended hours seven days per week a minimum of 350 days per year.	
✓ The clinic provides in-person urgent care services weekday evenings and during weekends and statutory holidays at any time.	
✓ The clinic sees all patients, whether attached or unattached/walk-ins.	
✓ The clinic provides onsite simple lab diagnostics and specimen collection (i.e., urinalysis, swabs, pregnancy tests and blood sugars).	
✓ The clinic provides:	
o Onsite Doppler fetal assessment	
o Onsite Electrocardiogram (ECG)	
o Onsite suturing	
o Onsite wound dressing and dressing changes	
o Onsite casting and/or splinting	
✓ The clinic provides access to radiology in a timely manner.	
✓ The clinic provides access to the Pharmaceutical Information Program (PIP) and eHealth.	
✓ The clinic is wheelchair accessible.	

Authorization for Release of Information

I hereby authorize the SMA to share information provided as part of this application with other stakeholders (i.e., clinic/hospital, Ministry of Health, SMA committees, section representatives, etc.) for the purpose of determining eligibility for reimbursement under the After-Hours Urgent Care Clinic Program.

I authorize for release of the information stated above and declare that the Clinic has the indicated onsite capabilities (i.e., equipment, personnel, and applicable licensing) for provision of after-hours urgent care services and understand that this declaration may be confirmed via site visit/audit.

Clinic Medical Director Signature: _____ Date: _____

Medical Director Printed Name: _____

B.	Payment Method		
	Electronic Fund Transfer (EFT) (see next page)		Cheque (Personal or Corporation name)

RETURN TO:
Email: economics@sma.sk.ca or Fax: 306.653.1631 Attention: Urgent Care Clinic Support Administrator

Note: Applications must be received 15 days in advance of the corresponding assessment period.

Direct Deposit (Electronic Fund Transfer – EFT) Authorization Form

ACCOUNT HOLDER NAME:

Surname		**First Name**			
Address					
City		**Province**		**Postal Code**	
Email Address					

A statement of what the clinic is being paid will be emailed to the clinic once the payment is deposited successfully into the account. Please indicate the email address you wish to receive this electronic statement.

BANKING INFORMATION:

Name of Financial Institution					
Branch Address					
City		**Province**		**Postal Code**	

Branch Number (5 digits)

Institution Number (3 digits)

Account Number (maximum 12 digits)

Please attach a **SAMPLE VOID CHEQUE** for the bank account you wish us to credit.

I/we hereby authorize the Saskatchewan Medical Association to credit the Payee account indicated above (or another account which I/we may subsequently authorize).

Signature		**Date**	

If the account is a joint account, that individual must also agree to the terms stated above by signing below.

Signature		**Date**	

RETURN TO:
Email: economics@sma.sk.ca or Fax: 306.653.1631
Attention: Urgent Care Clinic Support Administrator