Relocation Allowance Application Form

Zone: Eastern___Northern____Western____Central____(please check one)

Physician Name: _____

Address: _____

_____

Email: _____

Discipline:_____ **Subspecialty** _____

Community of Practice: _____

Date of Relocation: _____

Practice Start Date: _____

Zone Contact: _____

Please note: There is a minimum commitment of 1 year of full time practice within the community of practice. Physicians who do not meet this 1 year full time practice commitment will be required to payback monies received towards their relocation allowance reimbursement. Physicians must submit Relocation Allowance claims within 1 year of practice start date to receive reimbursement.

Signing this application form to participate in the Relocation Allowance Program, is with the understanding that you have agree to the terms of this application and that you have read, understood and agree to the Relocation Guidelines & Eligible Expenses.

Signature:_____

Date: _____

This section to be completed by Nova Scotia Health Authority

Approved_____Not Approved_____[Notes:_____**]**

Signature: _____

Date: _____