Flansberry Menard™
Associates | Associés

# MEDICINE INCORPORATION CHECKLIST

1. **FILE:** File No.:_____

2. **CLIENT:** Name:_____
Residential address:_____
Phone (H):_____
Phone (W):_____
Phone (C):_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

3. **PROPOSED NAMES IN ORDER OF PRIORITY:** *Name must be the same as registered with the college (SG will ensure proper restrictions are used) and must terminate by* ***PROFESSIONAL CORPORATION***
   1. _____
   2. _____
   3. _____

4. **NATURE OF BUSINESS (describe business):** *Give brief activity of Corporation*
   ☐ Medical ☐ Dental ☐ Other (Specify):_____

| |
|---|
| |

5. **JURISDICTION:** ☐ Ontario

6. **INCORPORATOR(S):**
   **Incorporator 1** Name:_____
   Residential address:_____
   Phone (H):_____
   Phone (W):_____
   Phone (C):_____
   Fax:_____
   Email:_____

**Incorporator 2**

Name:_____
Residential address:_____
Phone (H):_____
Phone (W):_____
Phone (C):_____
Fax:_____
Email:_____

7. **AUTHORIZED CAPITAL/SHARE STRUCTURE:** *(Special Share Capital to be drafted by SG)*

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8. **ADDRESS OF CORPORATION:**

**Registered address of Corporation (P.O. Box not accepted):**

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**Mailing address of Corporation (P.O. Box accepted):** ☐ Same as **Registered address**

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9. **DIRECTORS:** *A director must be a Professional*

**Min – Max Number of Directors:** ☐ 1-10 ☐ Other (enter number):_____

**Director 1**

Name:_____
Residential address:_____
_____
Phone :_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

**Director 2**

Name:_____
Residential address:_____
_____
Phone :_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

**Director 3**

Name:_____
Residential address:_____
_____
Phone :_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

10. **PRESIDENT:** *Must be a Professional*

Name:_____
Address:_____
_____
Phone :_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

**11. SECRETARY:** *Must be a Professional*

Name:_____
Address:_____
_____
Phone :_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

**12. TREASURER:** *Must be a Professional*

Name:_____
Address:_____
_____
Phone :_____
Fax:_____
Email:_____
*Professional Registration Number*:_____
*Social Insurance Number*:_____

**13. ACCOUNTANT:**

Name:_____
Address:_____
_____
Phone :_____
Fax:_____
Email:_____

**14. YEAR END:** ☐ December 31 ☐ Other (enter date):_____

**15. BANK:**

Name:_____
Branch Address:_____
_____
Phone :_____
Fax:_____

**16. SIGNING AUTHORITY:**

☐ President alone
☐ President or Secretary Treasurer
☐ The President & Secretary Treasurer together
☐ Other:_____

**17. COLLEGE APPLICATION FORM:** *ATTACHED AND SIGN DO NOT DATE*

18. **OTHER PRACTICING AT THE CLINIC:** *Provide Full Name, Address &* Registration *No.*

19. **ARE THE ABOVE GOING TO BE SHAREHOLDERS?** ☐ YES (If yes, please list) ☐ NO

20. **SHAREHOLDERS:** *Please advise if shareholder is a family member or minor.*
*MUST BE A PROFESSIONAL TO RECEIVE VOTING SHARES*
*FAMILY MEMBER MAY ONLY RECEIVE NON-VOTING SHARES*

**Shareholder 1**
Name:_____
Address:_____
_____
Number:_____
Class:_____
Consideration: ☐ $0.01 per share ☐ $1.00 per share
☐ Other:_____

**Shareholder 2**
Name:_____
Address:_____
_____
Number:_____
Class:_____
Consideration: ☐ $0.01 per share ☐ $1.00 per share
☐ Other:_____

**Shareholder 3**
Name:_____
Address:_____
_____
Number:_____
Class:_____
Consideration: ☐ $0.01 per share ☐ $1.00 per share
☐ Other:_____

**21. CORPORATE SEAL:** ☐ Yes ☐ No

**22. DATE BUSINESS TO START:** _____

**23. PAYROLL NO.:** ☐ Yes ☐ No
**How often paid:** ☐ Daily ☐ Weekly ☐ Bi weekly ☐ Monthly
**Is payroll service used:** ☐ Yes ☐ No
**No of employees (1st yr):** _____
**Start date of Employee:** _____
**1st payment date to employees:** _____
**Expected 1st year Payroll (if any):** _____

**24. HST:** ☐ Yes ☐ No
**Effective Start date of Registration:** _____
**Expected 1st year Revenues:** _____
**Method of filing:** ☐ More than SIX MILLION – **Monthly**
☐ More than FIVE HUNDRED THOUSAND-SIX MILLION – **Quarterly**
☐ FIVE HUNDRED THOUSAND or less – **Annually**

**25. SPECIAL NOTES:** *Are there any Sole Proprietorship to be cancelled? Provide name(s) and copy(ies) of registration*

**Name:** _____

**Signature:** _____

***Email the completed document to: info@trade-mark.ca***
***or click on the "SUBMIT BY E-MAIL" button***