# POSTGRADUATE MEDICAL EDUCATION

## APPLICATION FOR:

- ☐ Residency
- ☐ Clinical Fellowship
- ☐ Research Fellowship
- ☐ Elective

PLEASE TYPE

Surname: _____ Given Names: _____

Permanent Address: _____

_____

Mailing Address: _____

_____

Telephone Number: _____ Alt Telephone Number: _____

Email Address: _____ Fax Number: _____

## DATE YOU WISH TO COMMENCE TRAINING

_____

(Normally, programs begin July 1)

## 1. COUNTRY OF CITIZENSHIP

If not Canadian

- ☐ Landed Immigrant
- ☐ Visa (Cannot be Ontario Ministry of Health funded)

*Please provide proof of immigration status*

## 2. ALTERNATIVE FUNDING SOURCE

(eg. other than Ontario Ministry of Health)

- ☐ Other (Agency, Institution, etc.)
- ☐ Foreign Government Sponsorship

(Please provide letter from government)

## 3. LANGUAGE OF INSTRUCTION OF MEDICAL SCHOOL

- ☐ English
- ☐ French
- ☐ Other:

## 4. MEDICAL COUNCIL OF CANADA EVALUATING EXAMINATION (MCCEE)

(For international graduates only)

- ☐ Have written, awaiting results
- ☐ Successful results attached

## 5. SPECIALTY CERTIFICATION

Are you a qualified specialist in your country?
(Please attach certificate)

- ☐ Yes
- ☐ No

## CURRENTLY LICENSED IN

(Do no include Postgraduate Certificate)

Province/State: _____ Country: _____

Year: _____ Certificate Number: _____

## MEDICAL EDUCATION

Medical School: _____ Address: _____

Country: _____ Degree: _____ Year Granted: _____

## POSTGRADUATE MEDICAL EDUCATION

(Internship, Residencies, etc.)

a) *Must be completed. Do no refer to curriculum vitae.*

| UNIVERSITY | ADDRESS | PERIOD | POSITION HELD |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

b) Have you ever withdrawn or been required to withdraw from any postgraduate medical training program?

☐ Yes

☐ No

If yes, please explain: _____

c) Have you ever been disciplined by a University or medical authority?

☐ Yes

☐ No

If yes, please explain: _____

d) Have you ever had your medical license suspended or revoked in any jurisdiction?

☐ Yes

☐ No

If yes, please explain: _____

e) Have you completed part of your training?

☐ Yes

☐ No

If yes, briefly list what further training you require in order to be eligible for the specialty examinations in which you plan to sit (eg. six months Pathology, six months Neonatology):

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f) Have you ever been enrolled in a Pre-Entry Assessment Program?

☐ Yes

☐ No

Did you successfully complete the program?

☐ Yes

☐ No

Please list the University, specialty, and program dates:

| University | Specialty | Start | End |
|---|---|---|---|
| | | | |
| | | | |

PLEASE ADD THE FOLLOWING INFORMATION:

a) Curriculum vitae – include information on teaching and research positions, list of publications, certificates, awards, scholarships, memberships, etc.

b) Medical School Transcripts

## 6. REFEREES: NAME, TITLE, ADDRESS AND TELEPHONE NUMBER OF THREE INDIVIDUALS WHO YOU HAVE ASKED TO BE YOUR REFEREES

*Your most recent program director must be included*

| Name | Title | Address | Telephone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I certify that the information recorded herein is complete and accurate. I recognize that any falsified documentation or evidence at the time, or subsequently found, will be basis for dismissal from the program. I hereby grant my permission to contact previous program director or any person/institution cited in this application or appendices for further reference.

Date: _____ Signature: _____

**Return to:** **Office of Postgraduate Medical Education**
Faculty of Health Sciences
McMaster University
1200 Main Street West, MDCL 3101
Hamilton, ON Canada L8N 3Z5

Phone: 905-525-9140 x22116 or x22118
Fax: 905-527-2707

For more information please see our website: www.fhs.mcmaster.ca/postgrad/

PLEASE TYPE

SURNAME: _____

GIVEN NAMES: _____

CURRENT ADDRESS:

_____

_____

_____

_____

_____

PHONE NUMBER: _____

This sheet will be detached and retained in the Postgraduate Office. Program Admissions Committees will receive a copy of the application form without this sheet.

_____

SIGNATURE

RESIDENCY ☐ FELLOWSHIP ☐

ANESTHESIA ☐

COMMUNITY MEDICINE ☐

CRITICAL CARE ☐

FAMILY MEDICINE ☐

SUBSPECIALTY _____

INTERNAL MEDICINE ☐

SUBSPECIALTY _____

LABORATORY MEDICINE ☐

SUBSPECIALTY _____

OBSTETRICS & GYNECOLOGY ☐

ONCOLOGY ☐

SUBSPECIALTY _____

PEDIATRICS ☐

SUBSPECIALTY _____

PSYCHIATRY ☐

RADIOLOGY ☐

SURGERY ☐

SUBSPEIALTY _____