



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 not 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 not 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b) Have you ever withdrawn or been required to withdraw from any postgraduate medical training program?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):

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 3113
 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: _____

RESIDENCY FELLOWSHIP

GIVEN NAMES: _____

ANESTHESIA

CURRENT ADDRESS: _____

COMMUNITY MEDICINE

CRITICAL CARE

FAMILY MEDICINE

SUBSPECIALTY _____

PHONE NUMBER: _____

INTERNAL MEDICINE

SUBSPECIALTY _____

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.

LABORATORY MEDICINE

SUBSPECIALTY _____

OBSTETRICS & GYNECOLOGY

ONCOLOGY

SUBSPECIALTY _____

PEDIATRICS

SUBSPECIALTY _____

PSYCHIATRY

SIGNATURE _____

RADIOLOGY

SURGERY

SUBSPECIALTY _____