DEPARTMENT OF PAEDIATRICS
THE HOSPITAL FOR SICK CHILDREN
UNIVERSITY OF TORONTO

APPLICATION FOR POSTGRADUATE FELLOWSHIP TRAINING

SUBSPECIALTY APPLYING FOR: _____ **FELLOWSHIP APPLYING FOR:** _____

Training dates requested: From: _____ To: _____

Last Name _____ First Name _____ Initial _____

Address _____

City _____ Province/State _____ Postal/Zip Code _____

Country _____

Email: _____

CITIZENSHIP: _____

Status: _____

If a work permit is required, please indicate the location of the Canadian Immigration office nearest you. This information is available from any Canadian Consulate or Embassy.

Nearest Office: _____

LICENSING

Are you currently licensed to practice medicine in the Province of Ontario? _____

If yes: Independent practise license number _____ Expiry Date: _____

OR

Ontario Postgraduate certificate of registration number _____ Expiry Date: _____

Have you ever been subject to any disciplinary action or license suspension by any licensing authority? If so, please provide details in an accompanying letter. _____

EDUCATION AND TRAINING

Medical School:

Institution and Location _____

Year of Graduation _____ Degree Earned _____

Internship :

Institution and Location _____

Type of Internship _____ Start Date: _____ End Date: _____

Postgraduate Residency and Fellowship Training:

Position		Institution and Location		Start date End date	
Position		Institution and Location		Start date End date	
Position		Institution and Location		Start date End date	
Position		Institution and Location		Start date End date	
Position		Institution and Location		Start date End date	
Position		Institution and Location		Start date End date	

Specialty Certification:

Type		Date Received	
Type		Date Received	
Type		Date Received	

REFERENCES:

Please ask three referees to send letters directly to the program to which you are applying, and list their names, titles and positions below.

Reference 1 _____

Reference 2 _____

Reference 3 _____

Emergency Contact:

Name and Relationship _____ Phone Number _____ Email _____

I certify that the information provided in this application is correct and complete, to the best of my knowledge.

_____ Date _____

Signature of Applicant

Please print the completed application form and email it along with the documents below to the Program Administrator.

- ☐ Current curriculum vitae
- ☐ Copy of original medical degree, and certified translation (if applicable)
- ☐ Copy of original paediatric specialty certificate and certified translation (if applicable)
- ☐ Copy of passport
- ☐ Copy of landed immigrant status (if applicable)
- ☐ Three letters of reference (sent directly to program by referees)
- ☐ Medical school transcripts
- ☐ Personal letter

Print Form