SickKids®
THE HOSPITAL FOR
SICK CHILDREN

UNIVERSITY OF
TORONTO

DIVISION OF PAEDIATRIC DERMATOLOGY
DEPARTMENT OF PAEDIATRICS THE HOSPITAL FOR SICK CHILDREN
UNIVERSITY OF TORONTO
APPLICATION FOR POSTGRADUATE FELLOWSHIP TRAINING IN PAEDIATRIC DERMATOLOGY

COMPLETED POSTGRADUATE TRAINING IN:

☐ Paediatrics ☐ Dermatology

For which fellowship program would you like to be considered? Please select one OR MORE of the following:

☐ Clinical Paediatric Dermatology Fellowship ☐ Advanced Fellowship in Epidermolysis Bullosa

☐ Advanced Fellowship in Paediatric Inflammatory Dermatoses

TRAINING DATES REQUESTED:

from ______________________ ______________________
day/month/year day/month/year

CONTACT INFORMATION

Name ____
Surname Middle First

Permanent Address ____
Street Number Street Name
____
City Province, Country Postal/Zip Code

Current Mailing Address
(if different from above) ____
Street Number Street Name
____
City Province, Country Posta/Zip Code

Telephone Numbers

Primary Secondary

Email Adresses

Primary Alternate

Social Insurance Number (If Canadian) ______________________

Country of Birth ______________________

CITIZENSHIP STATUS: (please check one)

☐ Canadian Citizen

☐ Landed Immigrant (Please enclose a copy, front and back, of your Permanent Resident Card)

☐ Work Permit Visa Required

LICENSING:

Are you currently licensed to practice medicine in the Province of Ontario? Yes ☐ No ☐

If yes: Independent practice 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:

A) Medical School:

Institution and Location | Year of Graduation | Degree earned

B) Internship:

Institution and Location | Type of Internship | Start & End Dates

C) Postgraduate Residency and Fellowship Training:

Position | Institution and Location | Start & End Dates

Position | Institution and Location | Start & End Dates

Position	Institution and Location	Start & End Dates
Position	Institution and Location	Start & End Dates
Position	Institution and Location	Start & End Dates

D) Specialty Certification:

Type	Date Received
Type	Date Received
Type	Date Received

FUNDING: (Please check one of the following)

- ☐ No Funding
- ☐ Funding Available, please specify: ____
- ☐ Other, please specify: ____

REFERENCES:

The program requires three (3) letters of reference to the attention of Dr. Irene Lara-Corrales. One must be from your current Program Director or current Supervisor. The letters can be emailed to paedsdermatology.fellowship@sickkids.ca. List the names, titles, positions of referees and emails below.

1. ____
2. ____
3. ____

Please give name, address, telephone number and relationship of an individual to be contacted in case of emergency:

____

____

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

Signature of Applicant

Date

Please include the following documents with the completed application form:

1) **Current curriculum vitae**
2) **Cover letter** (outlining goals/objectives for fellowship)
3) **Scanned copy of medical degree** (include translation if applicable)
4) **Scanned copy of your Paediatric and/or Dermatology Specialty Certificate** (include translation if applicable) OR **Letter of good standing from your current Program Director, indicating expected date of residency completion**
5) **Proof of landed immigrant status** (if applicable)

PLEASE ENSURE ALL DOCUMENTS ARE CLEAR AND IN PDF FORMAT.

Submit completed application package to:

Dermatology Education Coordinator
Email: paedsdermatology.fellowship@sickkids.ca