

**Clinical Fellowship Application
Division of Cardiovascular Surgery
The Hospital for Sick Children
University of Toronto**

Date of Appointment: (From) _____ (To) _____

Type of Fellowship: _____

PERSONAL INFORMATION:

1) **NAME:** _____
(Last) (First) (Middle)

2) **CURRENT ADDRESS:**

(Street Address)

(City/Town)

(Postal/Zip Code)

(Home Phone)

(Work Phone)

(Work fax)

e-mail address: _____

3) **PERMANENT ADDRESS:**

(Street Address)

(City / Town)

(Postal Code)

(Home Phone)

(Work Phone)

(Work fax)

4) **BIRTHDATE:** _____ **PLACE OF BIRTH:** _____
(Day) (Month) (Year)

5) **SOCIAL INSURANCE NUMBER:** _____

6) **CITIZENSHIP:** _____

CANADIAN LANDED IMMIGRANT: Yes _____ No _____

7) **LANGUAGES SPOKEN FLUENTLY:** English _____ Other _____

EDUCATION:

1) POST-GRADUATE TRAINING: (RESIDENCY)

Medical School: _____

City: _____ Country: _____

Degree Obtained: _____ Year: _____

2) MEDICAL EDUCATION:

Medical School: _____

City: _____ Country: _____

Degree Obtained: _____ Year: _____

3) EXAMINATIONS:

If you are a graduate of a medical school other than in Canada or the United States, which examination have you passed?

_____ Medical Council of Canada Evaluating Exam(MCCEE) / Date Passed: _____

_____ Medical Council of Canada Qualifying Exam (MCCQE) / Date Passed: _____

_____ Test of English as a Foreign Language (TOEFL iBT) / Mark: _____ (minimum 93)

4) LICENSURE:

Are you Registered with The College of Physicians & Surgeons of Ontario:

Yes: _____ In Progress: _____ No: _____

Type of License	Yes	No	License No.	Date of Expiry
General	_____	_____	_____	_____
Specialty	_____	_____	_____	_____
Educational	_____	_____	_____	_____

5) ADDITIONAL INFORMATION REQUIRED:

Please include an updated curriculum vitae, 3 reference letters and a statement of career goals with this application.

DECLARATION:

In making a clinical and/or research fellowship application to the Division of Cardiovascular Surgery, University of Toronto, I agree to abide by the By-Laws and by such Rules and Regulations of the Hospital Code of Ethics.

I hereby authorize The College of Physicians and Surgeons of Ontario to release to the Division of Cardiovascular Surgery, University of Toronto, information on myself held by the College. I also agree to register with the College of Physicians and Surgeons of Ontario (Educational Register) and as a Postgraduate Student in the University of Toronto.

Date: _____ Signature of Applicant: _____

Applicant:

Please forward the completed application, 3 reference letters and an updated curriculum vitae to your **supervisor**.
