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

TRAINING DATES REQUESTED:

from _____ to _____
day/month/year day/month/year

Name: _____
Surname First Middle

Current Mailing Address: _____
Street Number Street Name

_____
City Province/Country Postal/Zip Code

Permanent Address: _____
(if different from above) Street Number Street Name

_____
City Province/Country Postal/Zip Code

Social Insurance Number (if Canadian) _____

Country of Birth: _____

Telephone Numbers:

Home: _____

Work: _____

Email address: Alternate _____

email address: _____

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