UNIVERSITY OF BRITISH COLUMBIA

FACULTY OF MEDICINE

APPLICATION FOR POSTGRADUATE TRAINING

Please complete this form carefully either on-line or print with a black pen and mail or fax back ***signed*** to address at end of this application form. Thank you.

What year of specialty training are you applying for: PROGRAM:

R1 ☐ **R2** ☐ **R3** ☐ **R4** ☐ **R5** ☐ **R6** ☐ **Other** ☐

Normal date of entry to program is July 01. **Requested Date of Entry** (dd/mmm/yyyy)**:**

Please provide reasons if applying for entry at a different date.

1. Name:

(Last) (First) (Middle)

2. Name on Medical Degree (If different than above):

3. Current Address:

City:

Province/State:

Postal Code/ZIP: **Country:**

Telephone (xxx-xxx-xxxx)**:**

Fax (xxx-xxx-xxxx)**:**

E-mail:

Permanent Address:

City:

Province/State:

Postal Code/ZIP: **Country:**

Telephone (xxx-xxx-xxxx)**:**

Fax (xxx-xxx-xxxx)**:**

E-mail:

4. The language of instruction in the UBC Faculty of Medicine is English.
Please list any additional languages:

5. Citizenship:

6. **Are you:** **a Canadian Citizen** ☐
a Landed Immigrant/Permanent Resident ☐
on a Working Visa (Employment) ☐
a Certified Refugee ☐
Other (Please explain below) ☐

7. Social Insurance Number: **8. Date of Birth: yy/mm/dd**

9. Is your Postgraduate training funded by the Department of National Defence? Yes ☐ No ☐

10. Any other external source? Yes ☐ No ☐ If yes, please name source:

11. PRE-MEDICAL EDUCATION

COLLEGES AND UNIVERSITIES ATTENDED	FROM mmm/yyyy	TO mmm/yyyy	GRADUATE YEAR (yyyy)	DEGREE OBTAINED	MAJOR FIELD OF STUDY

♦♦♦♦ ***Please forward copies of transcripts during medical school*** ♦♦♦♦

12. UNDERGRADUATE MEDICAL EDUCATION

MEDICAL SCHOOL	ADDRESS	COUNTRY	DEGREE	YEAR GRANTED (yyyy)

13. EXAMINATIONS PASSED (Please enclose photocopies)

(a) Medical Council of Canada Evaluating Exam (dd/mmm/yyyy) **Evaluating Exam Candidate no.**

(b) Medical Council of Canada Qualifying Exam Part I (dd/mmm/yyyy) **Qualifying Exam Candidate no**

(c) Medical Council of Canada Qualifying Exam Part II (dd/mmm/yyyy) **Qualifying Exam Candidate no.**

(d) TOEFL with minimum score of 600 for graduates of medical schools other than U.S., U.K., Eire, Australia, New Zealand and South Africa:

(dd/mmm/yyyy) **score:**

14. POSTGRADUATE TRAINING

PGY1

(a) **Provide information regarding training.**

Institution:

Address:

Program Director or Preceptor:

Type of Program: **Dates (from mmm/yyyy to mmm/yyyy)**

PGYII and on

Institution:

Address:

Program Director or Preceptor:

Type of Program: **Dates (from mmm/yyyy to mmm/yyyy)**

(c) **If you have been registered or are currently registered in any other postgraduate training program (not internship). Please note this information.**

Program: **Dates (from [mmm/yyyy]-to[mmm/yyyy]-)**

Reasons for leaving position:

(d) **Have you ever withdrawn or been required or requested to withdraw from any postgraduate training program.**

Yes ☐ No ☐ If yes, please explain.

(e) **If you have already completed part of your training, briefly list what further training you require in order to be eligible for the specialty examinations you plan to sit (eg. 6 months pathology, 6 months neonatalogy). If your training has been assessed by either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, submit a copy of this assessment.**

15. **HONOURS: List any honours you have received while in professional school, eg. Scholarships, honour societies, graduation honours.**

16. **RESEARCH PROJECTS: List funded and non-funded research projects in which you have participated while in professional school. Provide citations and dates. Append information if necessary.**

17. **PUBLICATIONS: List original papers written while in professional school (published or accepted for publication). Append further information if necessary.**

TITLE:

JOURNAL:

18. **What are your career plans?**

Academic Practice:

Academic teaching, research position:

Community Practice:

Other, please specify:

19. **REFERENCES: Please provide names, academic title, institution and telephone number of your three references. Please have your referees send references to the Program Director.**

i.

ii.

iii.

20. **Please outline why you are interested in this program.**

VERIFICATION AUTHORIZATION/CERTIFICATION STATEMENT

I certify that the information recorded herein is complete and accurate to the best of my knowledge. I recognize that any misrepresentation or omission on my part may cause me to be disqualified from continuing in a residency program, if accepted on the basis of this information. I hereby grant my permission to contact previous program directors to verify this information.

DATE: ***SIGNATURE:*** ________________________________

Please return signed application to:

Dr. Gord Finlayson
Program Director, Adult Critical Care Training Program
Critical Care Medicine
Vancouver General Hospital
ICU2, JPN2, Room 2439
855 West 12th Avenue
Vancouver, BC V5Z 1M9

Or return signed application by Fax: 604-875-5957

Please be advised that we require a Certificate of Standing from your current or last licensure authority dated within 60 days prior to the commencement of your training.