THE UNIVERSITY OF BRITISH COLUMBIA

FACULTY OF MEDICINE

APPLICATIONS **MUST** BE RECEIVED BY OUR OFFICE NO LATER THAN **SEPTEMBER 1st**

APPLICATION FOR POSTGRADUATE TRAINING

Please complete this form carefully using a typewriter or black pen (please print)

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

R1 R2 R3 R 4 R 5 R 6 OTHER

Normal date of entry to program is July 01. Please provide reasons if applying for entry at a different date.

Requested Date Of Entry: _____

1. NAME: _____

(LAST) **(FIRST)** **(Middle)**

2. NAME ON MEDICAL DEGREE (If different than above): _____

3. Current Address:

_____

_____

City _____

Province _____ **PC** _____

Telephone _____

Fax _____

E-mail _____

Permanent Address:

_____

_____

City _____

Province _____ **PC** _____

Telephone _____

Fax _____

E-mail _____

4. The language of instruction in the UBC Faculty of Medicine is English.

Do you have a second Language? _____

5. Citizenship: _____

6. Landed Immigrant/Permanent Resident Working Visa (Employment)
Canadian Citizen Certified Refugee Other Explain: _____
_____

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

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

9. Any other external source? Yes No If yes, please name source: _____

10. PRE-MEDICAL EDUCATION

COLLEGES AND UNIVERSITIES ATTENDED	FROM	TO	GRADUATE YEAR	DEGREE OBTAINED	MAJOR FIELD OF STUDY

♦♦♦♦ ***Please forward copy of transcripts of marks during medical school*** ♦♦♦♦

11. UNDERGRADUATE MEDICAL EDUCATION

MEDICAL SCHOOL	ADDRESS	COUNTRY	DEGREE	YEAR GRANTED

12. EXAMINATIONS PASSED (Please enclose photocopies)

(a) Medical Council of Canada Evaluating Exam (date) _____ **Evaluating Exam Candidate no.** _____

(b) Medical Council of Canada Qualifying Exam Part I (date) _____ **Qualifying Exam Candidate no.** _____

(c) Medical Council of Canada Qualifying Exam Part II (date) _____ **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:

(date) _____ **score:** _____

13. POSTGRADUATE TRAINING

PGY1

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

Institution: _____

Address: _____

Program Director or Preceptor: _____

Type of Program: _____ **Dates (from-to)** _____

PGYII and on

(b) **Institution:** _____

Address: _____

Program Director or Preceptor: _____

Type of Program: _____ **Dates (from-to)** _____

(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-to)** _____

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.**

_____

_____

_____

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

_____

_____

_____

15. **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.**

_____

_____

_____

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

TITLE: _____

JOURNAL: _____

17. What are your career plans?

Academic Practice: _____

Academic teaching, research position: _____

Community Practice: _____

Other, please specify: _____

18. 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. _____

19. 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:*** _____

Return completed application and supporting documents to:

Dr. Kam Shojania
Program Director, Rheumatology
University of British Columbia
802 – 1200 Burrard St.
Vancouver, BC V6Z 2C7 CANADA

Applications and supporting documents MUST be received by our office BY September 1st.

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.