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?

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

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

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

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 and a photo 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: _____