



THE UNIVERSITY OF BRITISH COLUMBIA
FACULTY OF MEDICINE

APPLICATION FOR POSTGRADUATE TRAINING

Please complete this form carefully

PROGRAM NAME: _____

What year of specialty training are you applying for?

R1 R2 R3 R4 R5 R6 Other

The normal date of entry to this program is July 01. Please provide reasons if applying for a different date. Date of Entry July 1

Other Date of Entry Requested Reason: _____

Last Name

First Name

Middle Name

Name on Medical Degree (if different than above):

Address (Current)		Address (Permanent)	
Street		Street	
City		City	
Province		Province	
Post. Code		Post. Code	
Telephone		Telephone	
Email		Email	

The language of instruction in the UBC Faculty of Medicine is English. Do you have a second language? Yes No

Citizenship: _____ (check any categories below that apply)

Landed Immigrant/Permanent Resident

Working Visa (Employment)

Certified Refugee

Other Explain: _____

Social Insurance Number: _____

Date of Birth: _____ (yy\mm\dd)

Is your Postgraduate training funded by the Department of National Defence? Yes No
Or any other external source? Yes No If yes, please name source: _____

PRE-MEDICAL EDUCATION

COLLEGES AND UNIVERSITIES ATT'D	FM	TO	GRAD YEAR	DEGREE OBTAINED	MAJOR FIELD OF STUDY

Please forward copy of transcripts of marks during medical school

UNDERGRADUATE MEDICAL EDUCATION

MEDICAL SCHOOL	ADDRESS	COUNTRY	DEGR.	GRAD YEAR

EXAMINATIONS PASSED

- Medical Council of Canada Evaluating Exam (date) _____ (mm/yy/dd)
Evaluating Exam Candidate No. _____
- Medical Council of Canada Qualifying Exam Part I (date) _____ (mm/yy/dd)
Qualifying Exam Candidate No. _____
- Medical Council of Canada Qualifying Exam Part II (date) _____ (mm/yy/dd)
Qualifying Exam Candidate No. _____
- TOEFL with minimum score of 600 for graduates of medical schools other than U.S., U.K., Eire, Australia, New Zealand and South Africa: _____ (mm/yy/dd) score: _____

Please enclose photocopies

POSTGRADUATE TRAINING

PGY1

Institution	Address	Program Dir. or Preceptor	Type of Program	From	To

PGYII and on

Institution	Address	Program Dir. or Preceptor	Type of Program	From	To

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

Program	From	To	Reasons for Leaving Position

Have you ever withdrawn or been required or requested to withdraw from any postgraduate training program. No Yes If yes, please explain _____

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 neonatology).

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.

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

RESEARCH PROJECTS: List funded and non-funded research projects in which you have participated while in professional school. Provide citations and dates.

Research Project	Citation	Dates

Append further information if necessary

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

Title	Journal

What are your career plans?

Academic Practice: _____

Academic teaching, research position: _____

Community Practice: _____

Other, please specify: _____

REFERENCES

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

Reference	Academic Title	Institution	Telephone No.
1.			
2.			
3.			

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: _____ (mm/yy/dd)

SIGNATURE: _____

Return completed application to:

*Ms. Candy Ferris, Administrative Assistant
Leukemia/Bone Marrow Transplant Program of British Columbia
Division of Hematology
10th Floor, 2775 Laurel Street
Vancouver, BC V5Z 1M9
CANADA*

OR

cferris@bccancer.bc.ca

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.