**PAEDIATRIC ADVANCED CARE TEAM (PACT)**
**DIVISION OF PAEDIATRIC MEDICINE**
**DEPARTMENT OF PAEDIATRICS**
**THE HOSPITAL FOR SICK CHILDREN**
**UNIVERSITY OF TORONTO**

# APPLICATION FOR POSTGRADUATE FELLOWSHIP TRAINING

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**TRAINING DATES REQUESTED:**

from ______________________ to ______________________
day/month/year day/month/year

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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 (Canadian) ______________________

Date of Birth (dd/mm/yyyy) ______________________

Country of Birth: ______________________

Telephone Numbers:

Home: ( ) ______________________

Work: ( ) ______________________

Fax: ( ) ______________________

Email address: ______________________

**CITIZENSHIP STATUS: (please circle one)**

A. Canadian Citizen

B. Landed Immigrant (Please enclose a copy (front and back) of your permanent resident card).

C. Is a Work Permit Visa required? If so please provide:

Date of Birth (dd/mm/yyyy) ______________________________ (required for visa)

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**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. ________________________________

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**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 |

**REFERENCES:**

Please ask three referees to send letters to the attention of Dr. Natalie Jewitt, PACT Education Director. The letters can be emailed/mailed to Ms. Jenny Loor (see below for address). List the names, titles and positions of referees 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 enclose the following documents with the completed application form:

1) **Current curriculum vitae**
2) **Cover letter** (outlining goals/objectives for fellowship)
3) **Photocopy of medical degree** (include translation if applicable)
4) **Photocopy of your Paediatric** (include translation if applicable)
5) **Proof of landed immigrant status** (if applicable)

Submit completed application package to:

Jenny Loor
Rm. 5250A, 5th Floor, Black Wing
Paediatric Advanced Care Team (PACT), Division of Paediatric Medicine
The Hospital for Sick Children
555 University Avenue
Toronto, ON
M5G 1X8 Canada
Email: PACT.fellowship@sickkids.ca