DIVISION OF PAEDIATRIC MEDICINE
DEPARTMENT OF PAEDIATRICS
THE HOSPITAL FOR SICK CHILDREN
UNIVERSITY OF TORONTO

APPLICATION FOR POSTGRADUATE FELLOWSHIP TRAINING

SELECT POSITION APPLYING FOR:

- ☐ Paediatric Hospital Medicine
- ☐ Academic General Paediatrics
- ☐ Community Paediatrics
- ☐ Child Maltreatment Paediatrics
- ☐ Paediatric Palliative Care (PACT)
- ☐ Complex Care

TRAINING DATES REQUESTED:

from _____ (day/month/year) to _____ (day/month/year)

Name: _____
Surname First Middle

Current Mailing Address: _____
Street Number Street Name

_____
City Province/Country Postal/Zip Code

_____
Street Number Street Name

_____
City Province/Country Postal/Zip Code

Telephone Numbers:
Home: ( ) _____

Work: ( ) _____

Email address: _____

CITIZENSHIP STATUS: (please select one)

- ☐ Canadian Citizen
- ☐ Landed Immigrant (Please enclose a copy (front and back) of your permanent resident card).
- ☐ Work Permit Visa required

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. _____

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:

For all fellowship streams, please ask three referees to send letters of reference. One of the letters must be from your current Program Director, to the attention of Dr. Sarah Schwartz. The letters can be emailed to **paedmed.fellowship@sickkids.ca**, please see contact information at the end of the application form. Please 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 clinical and scholarly goals/objectives for fellowship)
3) **Photocopy of medical degree** (include translation if applicable)
4) **Photocopy of your Paediatric Specialty Certificate** (include translation if applicable)
5) **Proof of landed immigrant status** (if applicable)

Submit completed application package to:

Paediatric Medicine Education Coordinator
Rm 10203A, 10th Floor, Black Wing Division of Paediatric Medicine
Division of Paediatric Medicine
The Hospital for Sick Children
555 University Avenue
Toronto, ON
M5G 1X8 Canada
Email: paedmed.fellowship@sickkids.ca