**Application for Approval of Appointment of**

**Postgraduate (Fellow)**

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| Use this form if you are a post-medical degree trainee who wishes to pursue further clinical or research training and will be licensed by the College of Physicians and Surgeons of British Columbia (“CPSBC”) in the Educational – Postgraduate (Fellow) class as described in CPSBC bylaw 2-26.  Do NOT use this form if you seek appointment as an International Postgraduate Trainee (Elective). | | | | | | | | | | | | | | | | | | | |
| **Basic Information** | | | | | | | | | | | | | | | | | | | |
| Last Name: | Click here to enter text. | | | | | | | | First Name: | | | Click here to enter text. | | | | | | | |
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| Name (if different on medical degree): | | | | | | | Click here to enter text. | | | | | | | | M |  | F |  |  |
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| Date of Birth (m/d/yy): | | Click here to enter a date. | | | | | | | | Country of Birth: | | | | Click here to enter text. | | | | | |
| Citizenship: | | Click here to enter text. | | | | | | | | | | | | | | | | | |
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| Permanent Resident (Landed) | | | | |  | Work Permit | |  | |  | | | | | | | | | |
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| Address: | Click here to enter text. | | | | | | | | | | | | | | | | | | |
| City/Province: | Click here to enter text. | | | | | | | | Postal Code: | | | Click here to enter text. | | | | | | | |
| Cell Phone: | Click here to enter text. | | | | | | | | Email: | | | Click here to enter text. | | | | | | | |
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| **Medical Degree Information** | | | | | | | | | | | | | | | | | | | |
| University/College Name: | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| Medical Degree: | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| Date: | | | | Click here to enter a date. | | | | | | | Country: | | Click here to enter text. | | | | | | |
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| **Medical Council of Canada Examinations** | | | | | | | | | | | | | | | | | | | |
| MCCEE: | | | Click here to enter text. | | | | | | | | Date: | | Click here to enter a date. | | | | | | |
| MCCQE Part I: | | | Click here to enter text. | | | | | | | | Date: | | Click here to enter a date. | | | | | | |
| LMCC#: | | | Click here to enter text. | | | | | | | | Date: | | Click here to enter a date. | | | | | | |

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| **Specialty Certifications** | | | | | | | | | | | | | | | | | |
| RCPSC Certification: | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
| If from UK – CCST (Certification of Specialist Training): | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
| American Board Certification: | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
| Other: | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
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| **Program Information** | | | | | | | | | | | | | | | | | |
| In what specialty or subspecialty will the fellow be training? | | | | | | Click here to enter text. | | | | | | | | | | | |
| Training site(s) during appointment: | | | Click here to enter text. | | | | | | | | | | | | | | |
| Purpose of training: | | | Click here to enter text. | | | | | | | | | | | | | | |
| What specific knowledge and/or skills are being sought? | | | Click here to enter text. | | | | | | | | | | | | | | |
| What is the anticipated length of training? | | | Click here to enter text. | | | | | | | | | | | | | | |
| Start Date (m/d/yy): | Click here to enter a date. | | | End Date (m/d/yy): | | | | | | | | | Click here to enter a date. | | | | |
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| Is your proposed program of study realistically capable of completion in two years or less? | | | | | | | | | | No | |  | | Yes | |  |  |
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| In no, please explain: | | | Click here to enter text. | | | | | | | | | | | | | | |
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| Have you previously been registered and licensed by the  College of Physicians and Surgeons of British Columbia? | | | | | No | |  | | Yes | |  | | Date: | | Click here to enter a date. | | |
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| **Source of Funding for Appointment** | | | | | |
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|  | Ministry of Health - Alternative Payments Section | | | | $Click here to enter text. |
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|  | Ministry of Health - Mental Health Division | | | | $Click here to enter text. |
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|  | Hospital Operating Budget (account code:Click here to enter text.) | | | | $Click here to enter text. |
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|  | Hospital Department (account code:Click here to enter text. | | | | $Click here to enter text. |
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|  | Hospital Foundation | | | | $Click here to enter text. |
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|  | Vancouver Health Department | | | | $Click here to enter text. |
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|  | Military Funding | | | | $Click here to enter text. |
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|  | Country as Sponsor | | | | $Click here to enter text. |
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|  | Societies or Organizations | | | | $Click here to enter text. |
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|  | Charities or Religious Organizations | | | | $Click here to enter text. |
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|  | Grant Funded Fellowships | | | | $Click here to enter text. |
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|  | Self-Funded | | | | $Click here to enter text. |
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|  | | Other (please indicate) | Click here to enter text. |  | $Click here to enter text. |

\*Please append a current curriculum vitae outlining current postgraduate training\*

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| **Signature Page** | | |
| It is acknowledged that:   1. The training time and experience acquired in this appointment will not be used towards establishing eligibility for Canadian licensure, certification by the College of Family Physicians of Canada, or specialty or subspecialty certification by the Royal College of Physicians and Surgeons of Canada. 2. The time spent and medical services rendered by the individual in this appointment are for the purpose of physician training and will not be used to establish a need for the services of this physician in British Columbia. 3. The applicant must have the appropriate educational license granted by the CPSBC. It is the applicant’s responsibility to meet the criteria established by the CPSBC for licensure. The English language proficiency requirements as set out by the College of Physicians and Surgeons of British Columbia must be met. 4. CPSBC bylaws 2-26(4) and (5) provide that Postgraduate (Fellow) registration may be granted for a period of up to two years to provide an applicant with an opportunity to acquire further postgraduate training in the applicant’s specialty or sub-specialty. An extension for a further one year [for a maximum of three years of Postgraduate (Fellow) registration] may only be granted in exceptional or extenuating circumstances, upon request from the Associate or Assistant Dean, Office of Postgraduate Medical Education, UBC Faculty of Medicine. | | |
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| Signature of Postgraduate (Fellow): | Date: |  |
| Print: |  |
| Signature of Division Head or Supervisor (optional): | Date: |  |
| Print: |  |
| Signature of UBC Department Head: | Date: |  |
| Print: |  |
| Signature of Vice President, Medicine: | Date: |  |
| Print: |  |
| Signature of Associate/Assistant Dean,  UBC Postgraduate Medical Education: | Date: |  |
| Print: |  |