TRAINEE APPOINTMENTS

THE UNIVERSITY OF WESTERN ONTARIO FACULTY OF MEDICINE & DENTISTRY AND AFFILIATED TEACHING HOSPITALS

APPLICATION FOR CLINICAL/RESEARCH FELLOWSHIP IN THE DEPARTMENT OF ONCOLOGY

SURNAME: ____

GIVEN NAMES: ____

PERMANENT ADDRESS: ____

Apt/Street. No. **Street**

____

City /Province **Country** **Postal Code**

CURRENT ADDRESS: ____

Apt/Street. No. **Street**

____

City/Province **Country** **Postal Code**

____

Phone Number **Fax Number** **Email Address**

I hereby apply for a position as a Clinical/Research Fellow in:

Radiation Oncology ____________

Area of specialization interest:

Image Guidance _________

Brachytherapy _________

Paliative Care _________

Or:

Medical Oncology ______________

Area of specialization interest:

Personalized Medicine _________

Subspecialty (e.g. Head & Neck, Gyne, GU, GI, etc) ____

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Please indicate intended start date for training period (month/year) ________________

Please indicate duration of training period _________months.

Will you be self-funded by your Government or institution: Yes _____ No _____

1. Have you previously held an Ontario General Licence to practice Medicine? Yes ____ No ____

Licence #:___________________________

2. Which of the following examinations or qualifications have you passed? [Please provide proof of results]

a) Medical Council of Canada Evaluating Examination [MCCQE] ( )

i) Part 1 ( )

ii) Part 11 ( )

iii) Are you a licentiate of the Medical Council of Canada? ( )

Registration#____________

b) Medical Council of Canada Evaluating Examination [MCCEE] ( )

c) Federation of Licensing Authorities Examinations [FLEX]

d) Other (Please specify)... ( )

3. Previous College Certification and/or Board Examinations in Oncology

CERTIFYING BODY	SPECIALTY	COUNTRY	YEAR

4. Was the language of instruction at your medical school conducted completely in English? Yes/No

If no, you must complete both TSE and ITELS testing and submit scores.

5. Was the language of patient care during your medical school training conducted completely in English? Yes/No

If no, you must complete both TSE and IETLS testing and submit scores.

6. Please list language(s) that you are fluent in:

Written: ____________________

Spoken: ____________________

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7. ATTACHMENTS:

Please provide the following:

a) For graduates from other than Canadian Medical Schools, a copy of your Medical School Transcripts

b) For graduates from other than Canadian or US Medical Schools, a copy of your Medical School Degree

c) A copy of your Oncology specialist certification

8. REFEREES: Three letters of reference are required from teachers who have had a meaningful responsibility for your medical education. If you have recently obtained your Oncology certification, then one of your referees must be the program director in charge of Oncology training.

Please note that your application will not be considered until these letters of reference, which must be **mailed directly and independently by the referee**, have been received. You are responsible for asking the 3 referees to send their letter of references to us. **Please note, we will not accept referee forms that have been submitted by the applicant.**

Please provide the necessary contact information for each of your referees so that we may contact them if needed. It would assist us greatly if you would inform your referees ahead of time that they will be contacted by us.

1. **Name:**
   Nature of contact:
   Mailing address:
   Telephone:
   Fax number:
   Email address:

2. **Name:**
   Nature of contact:
   Mailing address:
   Telephone:
   Fax number:
   Email address:

3. **Name:**
   Nature of contact:
   Mailing address:
   Telephone:
   Fax number:
   Email address:

9. PRE-MEDICAL EDUCATION

University:
Dates of attendance:
Program:
Degree awarded:
Date of Graduation:

10. MEDICAL EDUCATION

University:
Medical School:
Dates of attendance:
Degree awarded:
Date of Graduation:

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11. POSTGRADUATE TRAINING: (Internships, Residencies, etc.)
Please list in chronological order all postgraduate training appointments from date of graduation, including hospitals, disciplines, duration and level of training.

PERIOD month & year	POSITION	PROGRAM	UNIVERSITY/ HOSPITAL	DIRECTOR/ SUPERVISOR

INTERNSHIP

RESIDENCY/FELLOWSHIP

12. List in chronological order, all of your professional appointments and type of practice including duration and location (Specify hospital, city, province, country) you have held since graduation.

1)
2)
3)
4)
5)
6)
7)

13. List all previous and current medical licences (Type and duration) in every jurisdiction since your graduation.

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14. List certificates, awards, scholarships, etc. and the year in which they were obtained.

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15. List of academic, teaching, and research activities.

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16. List of publication giving names of authors, titles, journals, etc.

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17. List of memberships in professional organizations.

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18. Reasons for the fellowship you are interested in; Please specify objectives and special interests.

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19. I certify that the above answers are accurate.

20. I certify that my Curriculum Vitae is accurate and complete.

SIGNATURE: ________________________ DATE: ______________________

PLEASE MAIL COMPLETED FORM TO: MS JEN FOXCROFT, DEPT. OF ONCOLOGY, LONDON HEALTH SCIENCES CENTRE, c/o LONDON REGIONAL CANCER PROGRAM,
790 COMMISSIONERS ROAD EAST, LONDON, ONTARIO, CANADA N6A 4L6.
PHONE : 1-519-685-8600 extension 53177 FAX: 1-519-685-8739
EMAIL: Jen.Foxcroft@lhsc.on.ca