TRAVELLING FELLOWSHIP PROGRAM APPLICATION

APPLICANT INFORMATION

Surname:_____ Given Name:_____ Initial:_____

Current Mailing Address:_____

Telephone: _____ Email:_____

Medical Education (institution and graduation year):_____

FELLOWSHIP INFORMATION

Fellowship Institution:_____

Address:

_____

Area of Specialty: _____

Academic Year Starting:_____ Years of Training Required:_____

PREVIOUS EXPERIENCE

Please list all appointments and positions (including residencies) since graduation. Include date, name of institution, and specialty/sub-specialty.

ESTIMATED COSTS

Please provide a yearly estimate of all costs associated with the fellowship (i.e. salary, benefits, administrative fees, etc.).

DECLARATION BY APPLICANT

I certify that all information given on this application is complete and true to the best of my knowledge. I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate repayment of current funding and disqualification from receiving future incentives. The Department of Health and Community Services has my consent to the collection, use and disclosure of my personal information in accordance with the ***Access to Information and Protection of Privacy Act, 2015****.*

Applicant Signature:_____ Date:_____

Please include the following documents along with your application:

- ☐ Verification of identity and current address is required (see policy for details).
- ☐ Certificate of Good Standing as a licensed physician in a Canadian Province or Country of Practice (must be dated within 6 weeks of application submission).
- ☐ Letter from the Director of the program being sought indicating acceptance to the program.
- ☐ Letter of commitment from NL Health Services indicating the need for the specialty/sub-specialty following completion of training.
- ☐ Two confidential reference letters from physicians who have personal knowledge of your work (*letters should be sent directly from the referring physicians to the address below*).
- ☐ Copy of Medical School diploma.

PLEASE RETURN COMPLETED APPLICATIONS VIA MAIL OR EMAIL TO:

Medical Services Division, Department of Health and Community Services
Confederation Building, P.O. Box 8700, St. John's, NL A1B 4J6
MedServicesPrograms@gov.nl.ca