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

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

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)

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:

Please ask three referees to send letters to the attention of Dr. Natalie Jewitt, PACT Education Director. The letters can be emailed to Stephanie Hardat (stephanie.hardat@sickkids.ca). 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 specialty certificate** (include translation if applicable)
5) **Proof of landed immigrant status** (if applicable)

Please email completed application package to:

Stephanie Hardat
Paediatric Advanced Care Team (PACT), Division of Paediatric Medicine
The Hospital for Sick Children
175 Elizabeth Street
Toronto, ON
M5G 2G3 Canada
Email: stephanie.hardat@sickkids.ca