



11. PRE-MEDICAL EDUCATION

Colleges & Universities Attended	From	To	Graduate Year	Degree Obtained	Major Field of Study

**Please forward copy of transcripts of marks during medical school**

12. UNDERGRADUATE MEDICAL EDUCATION

Medical School	Address	Country	Degree	Year Granted

13. EXAMINATIONS PASSED (Please enclose photocopies)

- (a) Medical Council of Canada Evaluating Exam (date) \_\_\_\_\_ Evaluating Exam Candidate No. \_\_\_\_\_
- (b) Medical Council of Canada Qualifying Exam Part I (date) \_\_\_\_\_ Qualifying Exam Candidate No. \_\_\_\_\_
- (c) Medical Council of Canada Qualifying Exam Part II (date) \_\_\_\_\_ Qualifying Exam Candidate No. \_\_\_\_\_
- (d) TOEFL with a minimum score of 600 for graduates of medical schools other than US, UK, Eire, Australia, New Zealand & South Africa  
 (date) \_\_\_\_\_ Score \_\_\_\_\_

14. POSTGRADUATE TRAINING

**PGY-1**

- (a) Provide information regarding training:

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Program Director or Preceptor: \_\_\_\_\_

Type of Program: \_\_\_\_\_ Dates (from-to) \_\_\_\_\_

**PGY-2 and on**

- (b) Provide information regarding training:

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Program Director or Preceptor: \_\_\_\_\_

Type of Program: \_\_\_\_\_ Dates (from-to) \_\_\_\_\_

(c) If you have been registered or are currently registered in any other postgraduate training program (not internship). Please note this information.

Program: \_\_\_\_\_ Dates (from-to) \_\_\_\_\_

Reasons for leaving position: \_\_\_\_\_

(d) Have you ever withdrawn or been required or requested to withdraw from any postgraduate training program?

Yes

No

If yes, please explain

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(e) If you have already completed part of your training, briefly list what further training you require in order to be eligible for the specialty examinations you plan to sit (eg. 6 months pathology, 6 months neonatology). If your training has been assessed by either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, submit a copy of this assessment.

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15. HONOURS: List any honours you have received while in professional school, eg. Scholarships, honour societies, graduation honours.

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16. RESEARCH PROJECTS: List funded and non-funded research projects in which you have participated while in professional school. Provide citations and dates. Append information if necessary.

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17. PUBLICATIONS: List original papers written while in professional school (published or accepted for publication). Append further information if necessary.

TITLE: \_\_\_\_\_

JOURNAL: \_\_\_\_\_

18. What are your career plans?

Academic Practice: \_\_\_\_\_

Academic Teaching, research position: \_\_\_\_\_

Community Practice: \_\_\_\_\_

Other, please specify: \_\_\_\_\_

19. REFERENCES: Please provide name, academic title, institution and telephone number of your three references. Please have your referees send references to the Program Director.

i. \_\_\_\_\_

ii. \_\_\_\_\_

iii. \_\_\_\_\_

20. Please outline why you are interested in this program.

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**VERIFICATION AUTHORIZATION/CERTIFICATION STATEMENT**

*I certify that the information recorded herein is complete and accurate to the best of my knowledge. I recognize that any misrepresentation or omission on my part may cause me to be disqualified from continuing in a residency program, if accepted on the basis of this information. I hereby grant my permission to contact previous program directors to verify this information.*

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Return application to:

Mrs. Betty Cristofoli  
Rm 5910B, St. Paul's Hospital  
1081 Burrard Street  
Vancouver, BC  
V6Z 1Y6