APPLICATION FORM – Department of Surgery

University of Toronto Sports Medicine Fellowship Program

Specific Area of Interest (if any):

Name of Supervisor you wish to work with (if known):

Name of Hospital you wish to work in (if known):

Period of Time Applied for: From: August 1, _____ To: July 31, _____
Year Year

Should you require a different start date please indicate the reasoning as well as the month you are available to start:

PERSONAL INFORMATION:

NAME: _____
CURRENT ADDRESS: _____
Home phone: _____
Business phone: _____
Fax: _____

Email: _____

Place of Birth: _____

Citizenship: _____

Landed Immigrant: No ☐ Yes ☐

Languages spoken fluently: English ☐ French ☐ Other (specify): _____

EDUCATION:

Medical Education:

Name of Medical School: _____

City: _____ Country: _____

Degree obtained: _____ Year: _____

Postgraduate Training:

Name of Medical School: _____

City: _____ Country: _____

Dates of training completed: _____ to _____

Specialty Certification:

Name of Licensing Body: _____

City: _____ Country: _____

Degree obtained: _____ Year: _____

EXAMINATIONS:

Medical Council of Canada Evaluating Examination (MCCEE)

☐ Yes Date passed: _____

☐ No

Please note: If you are a graduate of a medical school other than in Canada or the United States and your language of instruction and patient care was not conducted in English you must provide proof of:

Test of English as a Foreign Language (TOEFL not IELTS) with a minimum score of 237 and
Test of Spoken English (TSE) with a minimum score of 50 or
Test of English as a Foreign Language Internet-based test (TOEFL iBT) with a minimum overall score of 93 including a minimum score of 24 on the speaking section

FUNDING:

Do you have funding?

☐ No
☐ Yes

AGREEMENT:

I understand that any offer of Fellowship training is contingent upon my ability to fulfill the licensing requirements of the College of Physicians and Surgeons of Ontario.

I understand that Fellowship training cannot be accredited toward certification by the Royal College of Physicians and Surgeons of Canada.

If accepted for postgraduate training, I agree to register with the University of Toronto, Department of Postgraduate Medical Education each year during the training period and pay the annual registration fee.

Signature: _____
Date: _____

A COMPLETE APPLICATION MUST INCLUDE:

1. An application form
2. A current Curriculum Vitae
3. 3 letters of reference
4. A letter of intent
5. A copy of your medical diploma (with translations if applicable)
6. A copy of your specialty certification or a letter from your program director stating when this certification will be completed (with translations if applicable)
7. A copy of your transcript of Medical School marks
8. Copies of your TOEFL and TSE scores (if applicable)
9. Proof of funding letter (if applicable)

***Please do not post your applications. Please email your completed application packages to utosmfellowship@utoronto.ca