*Return Completed forms to dfmadmin@mun.ca

CURRICULUM VITAE FORM

PART-TIME FACULTY, FACULTY OF MEDICINE
MEMORIAL UNIVERSITY

Name: ______________________________

Business Address: ______________________________

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Telephone: ______________________________

Fax: ______________________________

E-Mail Address: ______________________________

Canadian Citizen: ☐ Landed Immigrant: ☐

EDUCATION:

Degrees:
(include year & school)

Postgraduate Training:
(include year & school/program)

Certification: ☐ CCFP ☐ RCPCS ☐ Other
Please specify

Year of Certification:

CONTINUING EDUCATION PROGRAM:
Select appropriate program, if applicable

☐ College of Family Physicians of Canada ☐ Royal College Maintcert ☐ Royal College CPD

Name:

PRACTICE:

Licensure: Full ☐ Provisional ☐

Practice History:
Last 5 years

TEACHING EXPERIENCE:

List all involvement in teaching MUN students/residents and indicate years and practice location

PUBLICATIONS *(up to 5)*:

Name:

PROFESSIONAL ASSOCIATIONS/SOCIETIES:

If involved in professional association/society committees, please indicate & describe

COMMUNITY ACTIVITIES:

PERSONAL STATEMENT *(what is your interest or involvement in medical education)*: