MEMORIAL UNIVERSITY
Faculty of Medicine

DISCIPLINE OF FAMILY MEDICINE
ENHANCED SKILLS IN CARE OF THE ELDERLY

Full Name *(last name, first name)* _____

Preferred First Name_____ Previous Surname *(if applicable)* _____

Street Address _____ City _____

Province _____Postal Code _____ Email _____

Home Phone _____Work Phone _____ Fax _____

Have you previously attended Memorial? _____ If yes, when? _____

MUN student number *(if known)* _____

Country of Birth _____

Canadian Immigration Status - **Provide verification**: ☐ Citizen ☐ Permanent Resident ☐ Student Visa (Current Cdn MDs only)

Date of Entry to Canada *(DD/MM/YYYY)* _____

Date of Birth *(DD/MM/YYYY)* _____ Gender_____

NEXT OF KIN INFORMATION

Relationship to Applicant _____

Full Name *(last name, first name)* _____

Address: ☐ **SAME AS ABOVE** or:

Street _____ City _____

Province _____ Postal Code _____ Country_____

Phone _____Email _____

MEDICAL EDUCATION – Provide copy of MD degree

Name of University or School of Medicine granting Degree of Medicine:

_____

Date MD granted: _____

Complete address of University or School of Medicine:

_____

_____

_____

POSTGRADUATE MEDICAL EDUCATION – All time periods from graduation must be accounted for.
Provide verification of postgraduate training.

Dates (from-to)	Resident/ Fellow	Specialty	Medical School /Hospital	Country

PRACTICE HISTORY

In chronological order, list where you have practiced medicine. If you are not currently practicing, please indicate the last date on which you were in active clinical practice.

Dates (from-to)	Position	Hospital/Clinic	Country

DECLARATION - INTERRUPTION(S) IN UNDERGRADUATE/ POSTGRADUATE TRAINING AND/OR CLINICAL PRACTICE (IF APPLICABLE)

I declare that, since admission to medical school, I had interruptions of two continuous months or more during my undergraduate/postgraduate training and/or clinical practice on the following occasions:

Dates (Mo./Yr. to Mo./Yr.)	Reason for Interruption (Explain the reason for the interruption, e.g. maternity leave, vacation, emigration) **ATTACH ADDITIONAL PAGES AS NECESSARY**

I make this declaration conscientiously believing it to be true, and knowing that it is of the same legal force and effect as if made under oath.

Applicant's Signature	Print Name	Date

MEDICAL COUNCIL & CERTIFICATIONS

Indicate what Medical Council of Canada Exams you have passed as well as any additional certifications such as CFPC and Enhanced Skills. **A copy of the letter(s) confirming results is required.**

- ☐ MCCEE – Required by International Medical Graduates
- ☐ MCCQE Part I
- ☐ MCCQE Part II
- ☐ CFPC
- ☐ Enhanced Skills Certification

  Please write in the Enhanced Skills program(s) you have completed.

  _____

NATIONAL ASSESSMENT COLLABORATION OBJECTIVE STRUCTURE CLINICAL EXAMINATION (NAC OSCE)

A copy of the letter confirming you have passed is required.

☐ NAC OSCE – Required by International Medical Graduates

Score received _____

ENGLISH LANGUAGE PROFICIENCY

If English is your first language please tick the box below. If it is not, please complete the additional information.The College of Physicians and Surgeons of Newfoundland and Labrador will require TOEFL iBT or IELTS if your first language is not English and the language of patient care at your medical school was not English. **Copy of exam results is required.**

☐ English is my first language

First language _____

☐ Test of English as Foreign Language – Internet Based Test (TOEFL iBT): **Minimum total score 92.**

Total Score _____ Examination date _____

Reading Score (**Min 20**) ____Writing Score (**Min 20**) _____Listening Score (**Min 20**) _____ Speaking Score (**Min 24**)_____

☐ International English Language Testing System (IELTS): **Minimum 7.0 in each of the components.**

Score _____ Examination date _____

Reading Score _____ Writing Score _____ Listening Score _____ Speaking Score _____

Current **BLS** is required for commencement of any postgraduate training. **Provide verification.**

☐ Basic Life Support (BLS) – Current within 12 months

VERIFICATION OF DOCUMENTS – Physicians Apply

The College of Physicians and Surgeons of Newfoundland and Labrador require all IMGs to submit their medical credentials to physiciansapply.ca for verification; this includes medical degree, medical school transcript, all postgraduate training, and specialty certificates and registrations. **This process can take several weeks, or months, to complete**; therefore, individuals are urged to take care of this matter **immediately** following notification of a successful transfer.

REFERENCES

Three letters of reference from physicians who have personal knowledge of your recent training, and/or practice experience, are to be sent directly to the PGME office. **List the names, e-mail and mailing addresses of your references below**:

1. _____

2. _____

3. _____

In addition to submission of this completed application, and all supporting documents, you must include the following:

1. Detailed resume/curriculum vitae
2. Personal letter (outlining career objectives and any applicable practice experience in care of the elderly.)

All documents must be in English, or **be accompanied by a certified English translation.** The documents will become property of PGME and **will not be returned.** Please submit documents by mail, fax, or email, to:

- Postgraduate Medical Education
  Suite M2M401A, Health Sciences Centre, 300 Prince Philip Drive
  Faculty of Medicine, Memorial University A1B 3V6
- Fax: 709 864 6361
- E-mail: pgme@mun.ca

UPON ACCEPTANCE, THE FOLLOWING IS REQUIRED:

1. Payment of registration fees to Memorial University of Newfoundland ($675.58 - subject to change - we will notify you when payment of fees is due)
2. Registration with the CMPA (Malpractice Insurance)
3. Immunization documentation
4. Submission of the Blood Borne Pathogens Policy Declaration form
5. Registration with the College of Physicians and Surgeons of Newfoundland and Labrador
6. Adherence to the regulations of Memorial University of Newfoundland and the employer hospitals where they do not violate the Collective Agreement of the Professional Association of Interns and Residents of Newfoundland

I hereby apply for enrolment at Memorial University of Newfoundland and certify that the information contained herein is complete and correct. I understand that failure to disclose information required on this application form is considered to be an academic offence. If admitted, I agree to abide by all rules and regulations set out by the University. I make this Application in acknowledgement that it is subject to all of the provisions of current and future University Calendars which govern my course of study at the University, including, without restricting the generality of the foregoing, and all limitations and qualifications set out therein. I hereby authorize Memorial University of Newfoundland to obtain all relevant records from any school or post-secondary institution, which I have attended, and to release to agencies with a legitimate interest any non-confidential information. Please note that misrepresented or falsified educational credential information may be shared with other post-secondary institutions.

Signature: _____ **Date:** _____

MEMORIAL UNIVERSITY

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Postgraduate Medical Education
300 Prince Philip Drive
St. John's, NL Canada A1B 3V6
Tel: 709 864 6331 Fax: 709 864 6361
pgme@mun.ca www.med.mun.ca/pgme

Declaration

Have there ever been any disciplinary findings of guilt or sanctions made against you by a medical or other professional licensing authority?

Have you ever been found unfit to practice medicine or had restriction placed upon your practice for cause by a medical regulatory body?

Have you ever been found guilty of academic and/or professional misconduct in medical school that is currently part of your permanent record?

Do you have a return of service (ROS) obligation?

Specify the date on which you last practiced medicine in a clinical setting:

I verify that the above information is accurate.

Applicant's Name (Please Print)

Applicant's Signature

Date

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pgme@mun.ca www.med.mun.ca/pgme

CONSENT TO DISCLOSE

APPLICATION FOR RESIDENCY TRAINING AT MEMORIAL UNIVERSITY

I, _____, hereby authorize the Canadian Resident Matching Service (CaRMS) and the College of Physicians and Surgeons of Newfoundland and Labrador (College), to disclose a complete copy of my CaRMS application and College file pertaining to my Application for Educational Registration, including all documents submitted by me and all documents obtained by the College as part of the review of my Application, with the office of Postgraduate Medical Education at Memorial University.

This consent form is valid for a period of one year from the date of application to CaRMS.

_____
Applicant's Name (Please Print)

_____
Applicant's Signature

_____
Date

MEMORIAL UNIVERSITY
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Return from Practice Reference Request Information

To ensure program directors receive the information they need to evaluate applicants, we recommend reference documents include:

- A confidentiality statement indicating that the applicant has not seen and will not receive a copy of the reference.
- The date the reference was written.
- The time and duration of the referee's contact with the applicant.
- An assessment of the applicant's
    - Cognitive skills and knowledge
    - Problem solving and patient management skills
    - Behaviour and 'attitudinal skills'
    - Communication skills and working relationships
    - Motivation and punctuality
    - Sense of responsibility
    - Special qualities and unique contributions

If referees are unable to comment on a specific component of an applicant's performance in any of the above categories, they should indicate that they have not observed or do not have knowledge of that specific component in their reference.

Please select one of the following:

☐I would recommend this applicant without reservation
☐I would recommend this applicant
☐I would recommend this applicant with some reservation
☐I would not recommend this applicant