PRECEPTOR REMUNERATION
REQUEST FOR PERSONAL INFORMATION FORM

Faculty of Medicine, Memorial University

(COMPLETION OF THIS FORM IS REQUIRED ANNUALLY)

Memorial University protects your privacy and maintains the confidentiality of your personal information. If you have any questions about the collection and use of this information, please contact Distributed Medical Education at: dme@mun.ca

The information requested on this form is collected for the specific purpose as follows:

To approve payments for teaching services rendered to Memorial University medical learners and/or residents as outlined in the Preceptor Remuneration Policy

If Incorporated: (complete and sign this block)

Incorporated Name: _____ **Business #:** _____

Permanent Mailing Address:

_____
Street/PO Box

_____
City & Province

_____ **Daytime Contact #:** _____
Postal Code

Signature: _____ **Date:** _____

If not Incorporated: (complete and sign this block)

Name: _____ **SIN #:** _____

Permanent Mailing Address:

_____
Street/PO Box

_____ **Daytime Contact #:** _____
City & Province

_____ **MUN Student #:** _____
Postal Code (If applicable)

Signature: _____ **Date:** _____

Please email the completed form to: dmepayments@mun.ca