APPLICATION TO MEMORIAL UNIVERSITY OF NEWFOUNDLAND POSTGRADUATE TRAINING PROGRAMS
CORE CLINICAL CLERKSHIP DETAILS FOR INTERNATIONAL MEDICAL GRADUATES

Name of applicant: _____

Name of medical school: _____

Duration of basic medical degree program: _____

Start date of undergraduate medical education program: _____

End date of undergraduate medical education program: _____

**IMPORTANT**: This form MUST be stamped by your medical school verifying the information below is accurate. Without it, your application will be deemed incomplete.

| **Core clinical clerkship rotations** | **Name of hospital/clinic and location where rotation was completed** | **Is this facility a university affiliated *<u>teaching hospital</u>? Indicate YES or NO** | **Start & end dates of rotation (use format dd/mm/yy) & duration: (e.g. 8 weeks)** |
|---|---|---|---|
| Internal Medicine (minimum 8 weeks) | Facility:<br>City:<br>Country: | YES ☐ NO ☐<br>IF YES, PLEASE INDICATE NAME OF UNIVERSITY: | Start date:<br>End date:<br>Duration: |
| Surgery (minimum 8 weeks) | Facility:<br>City:<br>Country: | YES ☐ NO ☐<br>IF YES, PLEASE INDICATE NAME OF UNIVERSITY: | Start date:<br>End date:<br>Duration: |
| Pediatrics (minimum 6 weeks) | Facility:<br>City:<br>Country: | YES ☐ NO ☐<br>IF YES, PLEASE INDICATE NAME OF UNIVERSITY: | Start date:<br>End date:<br>Duration: |
| Obstetrics/Gynecology (minimum 4 weeks) | Facility:<br>City:<br>Country: | YES ☐ NO ☐<br>IF YES, PLEASE INDICATE NAME OF UNIVERSITY: | Start date:<br>End date:<br>Duration: |
| Psychiatry (minimum 4 weeks) | Facility:<br>City:<br>Country: | YES ☐ NO ☐<br>IF YES, PLEASE INDICATE NAME OF UNIVERSITY: | Start date:<br>End date:<br>Duration: |

* **A teaching hospital** is a hospital that provides clinical education and training to future and current doctors, nurses, and other health professionals, in addition to delivering medical care to patients. They are affiliated with medical schools or universities (hence the alternative term university hospital), and may be owned by a university or may form part of a wider regional or national health system.

**Proof of teaching hospital status must be provided. Proof can include a stamped letter from the medical school or direct email communication from the school/faculty office.**

**** If the rotation has not yet been completed, indicate <u>scheduled</u> start and end dates.**