

Application for Approval of Appointment of International Postgraduate Trainee (Elective)

Use this form if you are currently in a postgraduate training program outside of Canada or the United States and wish to acquire additional postgraduate training in a UBC sponsored postgraduate training program and will be registered in the College of Physicians and Surgeons of British Columbia (“CPSBC”) educational license – Postgraduate (Trainee) class as described in CPSBC bylaw 2-28.

Do NOT use this form if you seek appointment as a Postgraduate Fellow.

| Basic Information | | | |
|---|-----------------------------|-------------------|---|
| Last Name: | Click here to enter text. | First Name: | Click here to enter text. |
| Name (if different on medical degree): | Click here to enter text. | | M <input type="checkbox"/> F <input type="checkbox"/> |
| Date of Birth (m/d/yy): | Click here to enter a date. | Country of Birth: | Click here to enter text. |
| Citizenship: | Click here to enter text. | | |
| Permanent Resident (Landed) <input type="checkbox"/> Work Permit <input type="checkbox"/> | | | |
| Address: | Click here to enter text. | | |
| City/Province: | Click here to enter text. | Postal Code: | Click here to enter text. |
| Cell Phone: | Click here to enter text. | Email: | Click here to enter text. |

| Medical Degree Information | | | |
|----------------------------|-----------------------------|----------|---------------------------|
| University/College Name: | Click here to enter text. | | |
| Medical Degree: | Click here to enter text. | | |
| Date: | Click here to enter a date. | Country: | Click here to enter text. |

| Medical Council of Canada Examinations | | | |
|--|---------------------------|-------|-----------------------------|
| MCCEE: | Click here to enter text. | Date: | Click here to enter a date. |
| MCCQE Part I: | Click here to enter text. | Date: | Click here to enter a date. |
| LMCC#: | Click here to enter text. | Date: | Click here to enter a date. |

| Summary of Postgraduate Training Program to Date | |
|--|---------------------------|
| Country or Home Jurisdiction of Current Postgraduate Training: | Click here to enter text. |
| Discipline-specific Specialty/Practice of Current Postgraduate Training: | Click here to enter text. |
| Current Year of Postgraduate Training (PGY or Other): | Click here to enter text. |
| Anticipated Award of Specialty Certification by Home Jurisdiction: (e.g. UK–CCST; American Board of Specialty Certification; other) | Click here to enter text. |

Program Information

| | | | |
|---|-----------------------------|-----------------------------|------------------------------|
| In what specialty or subspecialty will the trainee be training? | | Click here to enter text. | |
| Training site(s) during appointment: | Click here to enter text. | | |
| Purpose of training: | Click here to enter text. | | |
| What specific knowledge and/or skills are being sought? | Click here to enter text. | | |
| What is the anticipated length of training? | | Click here to enter text. | |
| Start Date (m/d/yy): | Click here to enter a date. | End Date (m/d/yy): | Click here to enter a date. |
| Have you previously been registered and licensed by the College of Physicians and Surgeons of British Columbia? | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| | | Date: | Click here to enter a date. |

Source of Funding for Appointment

| | |
|---|-----------------------------|
| <input type="checkbox"/> Ministry of Health - Alternative Payments Section | \$Click here to enter text. |
| <input type="checkbox"/> Ministry of Health - Mental Health Division | \$Click here to enter text. |
| <input type="checkbox"/> Hospital Operating Budget (account code:Click here to enter text.) | \$Click here to enter text. |
| <input type="checkbox"/> Hospital Department (account code:Click here to enter text.) | \$Click here to enter text. |
| <input type="checkbox"/> Hospital Foundation | \$Click here to enter text. |
| <input type="checkbox"/> Vancouver Health Department | \$Click here to enter text. |
| <input type="checkbox"/> Military Funding | \$Click here to enter text. |
| <input type="checkbox"/> Country as Sponsor | \$Click here to enter text. |
| <input type="checkbox"/> Societies or Organizations | \$Click here to enter text. |
| <input type="checkbox"/> Charities or Religious Organizations | \$Click here to enter text. |
| <input type="checkbox"/> Grant Funded Fellowships | \$Click here to enter text. |
| <input type="checkbox"/> Self-Funded | \$Click here to enter text. |
| <input type="checkbox"/> Other (please indicate) Click here to enter text. | \$Click here to enter text. |

Please append a current curriculum vitae outlining current postgraduate training

Signature Page

It is acknowledged that:

1. The training time and experience acquired in this appointment will not be used towards establishing eligibility for Canadian licensure, certification by the College of Family Physicians of Canada, or specialty or subspecialty certification by the Royal College of Physicians and Surgeons of Canada.
2. The time spent and medical services rendered by the individual in this appointment are for the purpose of physician training and will not be used to establish a need for the services of this physician in British Columbia.
3. The applicant must have the appropriate educational license granted by the CPSBC. It is the applicant's responsibility to meet the criteria established by the CPSBC for licensure. The English language proficiency requirements as set out by the College of Physicians and Surgeons of British Columbia must be met.
4. The Postgraduate Trainee's home jurisdiction will recommend the duration of the postgraduate training experience of each trainee, subject to approval by the Associate or Assistant Dean, Office of Postgraduate Medical Education, UBC Faculty of Medicine.

| | | |
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| Signature of Postgraduate (Trainee): | Date: | |
| | Print: | |
| Signature of Division Head or Supervisor (optional): | Date: | |
| | Print: | |
| Signature of UBC Department Head: | Date: | |
| | Print: | |
| Signature of Vice President, Medicine: | Date: | |
| | Print: | |
| Signature of Associate/Assistant Dean, UBC Postgraduate Medical Education: | Date: | |
| | Print: | |