Rady Faculty of Health Sciences | University of Manitoba

APPLICATION FOR FELLOWSHIP
Department of Surgery – University of Manitoba
Health Sciences Centre
820 Sherbrook Street - Winnipeg Manitoba - Canada R3A 1R9

REQUESTED START: | | | | | | |
Month | Year

REQUESTED DURATION OF TRAINING: ❑ SIX MONTHS
(Dependent upon Program criterion for training) ❑ ONE YEAR
☐ TWO YEAR

Part I: Personal Data (or, as it appears on your medical degree if different) *(please print or type)*

Legal Family Name (Surname)	
Legal First (given) Name and Legal Middle Name(s)	

Birth Date (day | month | year)	| | |	Gender	❑ Male ❑ Female
Province or Country of Birth		Country of Citizenship	

Current Address ❑ **Check if same as Permanent / Forwarding Address**

Number and Street					
City and Province / State					
Country		Postal/Zip Code	| | | | |	Email	
Telephone (home) Area Code		Telephone (work) Area Code			

Permanent / Forwarding Address *This address will be used to forward your certificate upon successful completion of your fellowship*

Number and Street					
City and Province / State					
Country		Postal/Zip Code	| | | | |	Email	

Part 2: Status in Canada & Language Requirements

Citizenship:_____ Permanent Resident ❑ Landed Immigrant Status ❑ Work Permit ❑	If sponsored by an outside agency or Government, give name			Proposed or actual date of entry into Canada	- Day - |	- Month - |	- Year -
Primary Language	English ❑	French ❑	Other ❑ (please specify)	**If applicable**, date you wrote or plan to write IELTS ***(Results must be attached)***	- Day - |	- Month - |	- Year -

Part 3: Medical Degree, Specialty Certificate & Examinations

Name of University where medical degree was obtained			Country		Year of Graduation	
Specialty Certification ❑ RCPSC ❑ UK- CCST ❑ American Board ❑ Other:					Year Obtained	
Examinations ***(Results must be attached)*** ❑ MCCEE Date:	❑ MCCQE - Part I Date:	❑ MCCQE - Part 2 Date:	❑ USMLE-Step 1 Date:	❑ USMLE-Step 2 Date:	❑ USMLE-Step 3 Date:	

Signature: _____

_____
(print name)

Date
Day		Month		Year			