Rady Faculty of Health Sciences | University of Manitoba

WINNIPEG SPINE PROGRAM APPLICATION FOR FELLOWSHIP
Department of Surgery – University of Manitoba
GB137 – 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
❑

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:	

Part 4: Declaration

I hereby certify the above personal data is current and correct. I authorize the University of Manitoba-Department of Surgery to verify any information provided as part of my fellowship documentation and to contact any individuals, universities or other entities for the purpose of obtaining information as part of the Program's review of my application.

Signature: _____

(print name)

Date

Day | Month | Year