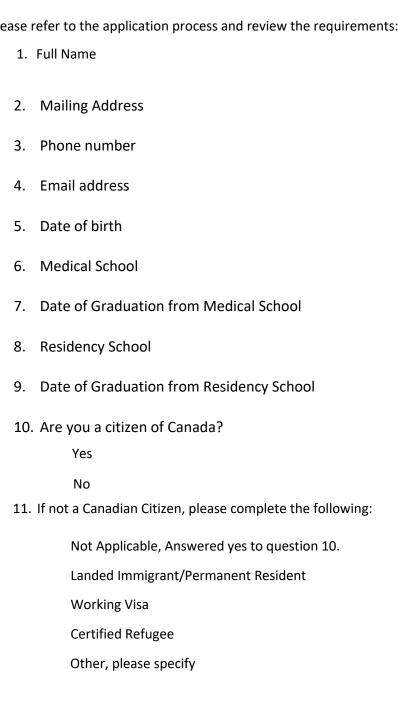


# Application for Category 2 Enhanced Skills (PGY3) Residency Program

Please fill in this form if you are applying for Chronic Pain (CP), Maternal and Newborn Care Program (MNC), Health Equity: Local and Global Care (HE) Program, Sexual and Reproductive Health (SRH) Program.

Please	refer to	the a	oplication	process and	review the	requirements:
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# PROGRAM INFORMATION

12.	Resident (R2) Department/Division
13.	Residency Program and Site
14.	Program Administrator's name, email, phone number
15.	Division Program Director's name, email, phone number
16.	Are you available to start Enhanced Skills Residency on July 1 of the incoming academic year. Yes
	No
17.	Do you currently hold an educational license in the province of Alberta?
	Yes
	No
18.	College of Physicians & Surgeons of Alberta (CPSA) License #
19.	Canadian Medical Protective Association (CMPA) #
20.	If not licensed in Alberta, are you eligible to be appointed as a postgraduate trainee to the
	educational register in Alberta?
	Not applicable, answered no to question number 17.
	Yes
	No



#### ADDITIONAL INFORMATION

21.	Have you ever been the subject of any type of investigation, inquiry or proceeding by a medica
	licensing authority relating to your professional conduct, competence, capacity, or any other
	aspect of your medical practice?

Yes

No

22. Have you ever had a medical license revoked, suspended, restricted, limited, or subjected to any other adverse action?

Yes

No

23. Has there been any legal proceeding, legal action, insurance or other claim that has in any way related to your practice of medicine or your professional activities?

Yes

No

24. Have you ever been denied privileges or been denied appointment or reappointment to the medical staff of a hospital or other health facility?

Yes

No

### APPLICATION FOR ENHANCED SKILLS PROGRAM

- 25. Which Enhanced Skills Program are you applying for?
- 26. Please provide the names, email and phone numbers of your referees. One referee must be your Program Director or Designate. The Department of Family Medicine will contact your referees directly.

## DISCLAIMER

By completing and submitting this application form, you certify that information recorded herein is complete and accurate to the best of your knowledge.

This is to attest that you recognize that any misrepresentation or omission on your own part may cause you to be disqualified from continuing a training program, if accepted on the basis of this information.

Further, you confirm that you are aware of no reason why this application would not be eligible for consideration.

Please email the completed application form to fmr3@ucalgary.ca.