UNIVERSITY OF CALGARY
CUMMING SCHOOL OF MEDICINE
Department of Family Medicine

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 application process and review the requirements:

1. Full Name
2. Mailing Address
3. Phone number
4. Email address
5. Date of birth
6. Medical School
7. Date of Graduation from Medical School
8. Residency School
9. Date of Graduation from Residency School
10. Are you a citizen of Canada?

    Yes

    No
11. If not a Canadian Citizen, please complete the following:

    Not Applicable, Answered yes to question 10.

    Landed Immigrant/Permanent Resident

    Working Visa

    Certified Refugee

    Other, please specify

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

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ADDITIONAL INFORMATION

21. Have you ever been the subject of any type of investigation, inquiry or proceeding by a medical 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.