UNIVERSITY OF CALGARY

Application for an Academic/Faculty Appointment

Department of Family Medicine

Faculty of Medicine, University of Calgary

PART 1 Personal Information

First Name: Middle Name: Last Name:

Clinic Name: Business Phone: Fax:

Clinic Address: "Private" Office Line:

City: Prov: Postal Code: Business Email:

Home Address: City: Prov: Postal Code:

Home Phone: Cell/Pager: Personal Email:

Preferred Method of Contact: ☐ Business Email ☐ Personal Email ☐ Fax

I am a: ☐ Family Physician ☐ Specialist: _____

PART 2

Please check and specify where appropriate:

☐ Current College of Family Physicians Canada (CFPC) Membership

☐ Certification in Family Medicine - Date of Certification: _____

☐ CFPC Special Designation: _____

☐ FRCPS(C) - Specialty: _____ Year: _____

Sub-specialty: _____ Year: _____

Other Training: _____

Areas of Special Interest:

Do you have a Medical Staff Appointment with Alberta Health Services (AHS privileges)?

☐ No ☐ Yes Hospital Affiliation (Name & Location)/Privileges: _____

PART 3 Areas of Preferred Contribution

Teaching:

☐ Clinical Teaching in Family Medicine Practice

☐ Clinical Teaching in Other Environment – please list:

_____

☐ Non-clinical Teaching – please list:

_____

What unique contribution to teaching would you like to make?

Research: ☐ Area(s) of Interest: _____

Do you have collaborative links at U of C? Please specify:

Do you have collaborative links elsewhere? Please specify:

Clinical Care: ☐ Area(s) of Interest: _____

Administration: ☐ Capacity: _____

PART 4 Mentorship

Please provide the name of a mentor (if applicable). If you are a recent graduate indicate a mentor who will act as a support in your practice and teaching:

Name: _____ Affiliation: _____

Business Address: _____ Business Phone: _____

City: _____ Prov: _____ Postal Code: _____ Email: _____

PART 5 Requirements

If appointed, I accept the following requirements for a faculty appointment in the Department of Family Medicine:

1) I will have and maintain an active membership of:
   - The College of Family Physicians of Canada or RCPSC
   - The College of Physicians and Surgeons of Alberta
2) I will provide, through mutual agreement, the teaching supervision as assigned by the University of Calgary and the Department of Family Medicine
3) I am aware I can participate in the Departmental committees as appropriate or through representation. If interested in serving, please indicate in what capacity:

_____

Signature: _____ **Date:** _____

Please Sign, Scan and Email completed form to: Sania.ali@ucalgary.ca

Contact our office with any questions or concerns:

Email: Sania.ali@ucalgary.ca Phone: Fax:

Please note that the submission of incomplete application forms will result in significant delays.

Thank you for your interest in the Department and for providing this information for clinical faculty application.

Alberta Health Services

medical affairs
calgary zone

REFERENCE CHECK FORM

Personal information that you provide on this form is collected under the authority of section 33(c) of the Freedom of Information and Protection of Privacy Act and is governed by the Health Information Act of Alberta. The information is collected and used for the purposes of identifying and regulating medical staff at Alberta Health Services and for managing the health system (s. 27). The information will only be disclosed to other agencies or for other purposes with the applicant's consent or to a health professional body for the purposes of investigation, discipline, practice review, or inspection of the medical staff member or in accordance with other legislation (s. 37).

CONSENT FOR RELEASE OF INFORMATION

I, (print)_____, authorize Alberta Health Services (including the Department of Family Medicine) to obtain personal and other information needed for determining my suitability for an Alberta Health Services Medical Staff appointment, an Impact Analysis, a University of Calgary Academic Appointment application or an application for a position in any of the Department of Family Medicine's six sections (Maternal Newborn, Medical Inpatient, Urgent Care, Seniors, Palliative Care or Community Primary Care). Information may be obtained from the named references as well as other practitioners, directors of postgraduate training programs, officers of licensing bodies or hospitals, with whom I have been associated.

I hereby release from liability Alberta Health Services, its Medical Staff and its representatives for any acts performed in good faith and without malice in connection with the gathering and exchange of information as consented to above, as well as the evaluation of my credentials and suitability for staff membership. I further release from liability all individuals and organizations who provide information to Alberta Health Services, its Medical Staff and its representatives in good faith and without malice concerning my competence, ethics and character for staff appointment and clinical privileges, including otherwise privileged or otherwise confidential information. Information obtained as consented above will be kept confidential, excepted as required by law and authorized by the Alberta Health Services Medical Staff Bylaws.

I understand why I have been asked to disclose this information and am aware of the risks or benefits of consenting or refusing to consent to disclose this information. I also understand that I may revoke this consent at any time by submitting a written revocation document to the Medical Staff Office or Department of Family Medicine.

_____ _____

SIGNATURE DATE

CHARACTER AND PROFESSIONAL COMPETENCE REFERENCES

REFEREE 1	Referee 1 Name			Phone
	Address			Relationship – title/institution
	City	Province/State	Postal Code/ZIP	Country
	Email Address			
	This Referee can attest to my character and professional competence based on firsthand knowledge within the last four years.			
REFEREE 2	Referee 2 Name			Phone
	Address			Relationship – title/institution
	City	Province/State	Postal Code/ZIP	Country
	Email Address			
	This Referee can attest to my character and professional competence based on firsthand knowledge within the last four years.			
REFEREE 3	Referee 3 Name			Phone
	Address			Relationship – title/institution
	City	Province/State	Postal Code/ZIP	Country
	Email Address			
	This Referee can attest to my character and professional competence based on firsthand knowledge within the last four years.			