

**POSTGRADUATE MEDICAL EDUCATION**

### *POSTGRADUATE MEDICAL TRAINING PROGRAM FRAMEWORK*

***FORM FOR CLINICAL FELLOWSHIPS - DOMESTIC***

This form is for recognized postgraduate medical training programs who wish to provide specialists with additional expertise without additional credentials for practice. The Office of PGME at the University of Calgary requires the submission of this form before issuing a postgraduate education certificate of registration for a clinical fellowship appointment.

**TRAINEE INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical Fellow:** | **Enter First Name Here** | | Enter Last Name **Here** |
| Enter Email **Here** | | Enter DOB Here | |
| **Specialty Certification:** | **Current Title of Certification:** | Enter Current Certification Here | |
|  |  | |
| **Country Issued this Certification:** | Enter Country - that issued the certification - Here | |
|  |  |  | |

**FELLOWSHIP GENERAL INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Funding Source:** | Enter Funding Source Here | | | | | |
| **Salary (annual):** | Enter Annual Salary Here | | | | | |
| **Salary Accounting Information:** | **Fund** | **Dept** | **Account** | **PC BU** | **Project** | **Activity Code** |
| Enter | Enter | Enter | Enter | Enter | Enter |
| **Employer:** | Enter Employer Here | | | | | |
| **Department Name:** | Enter Department Here | | | | | |
| **Division Name (if applicable):** | Enter Division Here | | | | | |
| **Name of Fellowship:** | Enter Fellowship Here | | | | | |
| **Fellowship Site:** | Enter Fellowship Site Here | | | | | |
| **Fellowship Start Date:** | Click arrow, then use calendar | | | | | |
| **Fellowship End Date:** | Click arrow, then use calendar | | | | | |
| **If re-appointment:** | | | | | | |
| **Re-appointment Start Date:** | Click arrow, then use calendar | | | | | |
| **Re-appointment End Date:** | Click arrow, then use calendar. | | | | | |
| **Name of Supervisor:** | Enter Supervisor Name Here | | | | | |
| **Telephone:** | Enter Supervisor Phone Number Here | | | | | |
| **Email:** | Enter Supervisor Email Address Here | | | | | |

**FELLOWSHIP OVERVIEW**

1. Please provide a brief statement of the clinical focus and educational purpose of the fellowship:

*If this fellowship is a re-appointment, please describe the clinical focus and educational purpose of the re-appointment only.*

Enter statement of clinical focus.

1. Please provide an estimated breakdown of time dedicated to education versus research versus clinical service provision during the fellowship:

Enter estimated breakdown of time.

1. Please list the type(s) and frequency of evaluations that will be used to document fellow progress through the program. As well, describe the process and frequency with which fellow progress in the program is reviewed.

Enter specific evaluation processes.

1. Please supply the Clinical Fellowship Director and Email address:

Clinical Fellowship Director Name and Email.

1. Please supply the Clinical Fellowship Committee Members Names:

Clinical Fellowship Committee Members

**FELLOWSHIP GOALS AND OBJECTIVES – CANMEDS ROLES**

Where applicable, please provide goals and objective(s) for each of the following: refer to Draft CanMEDS 2015 Framework.

*Enter* ***“N/A”*** *if individual CanMEDS is not applicable.*

1. ***Medical Expert***

As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional attitudes in their provision of high-quality and safe patient-centred care. Medical Expert is the central physician role in the CanMEDS framework and defines the physician’s clinical scope of practice. (Refer to pp. 9-11)

Click here to enter text.

## Communicator

As Communicators, physicians form relationships with patients and their families\* that facilitate the gathering and sharing of information essential for exemplary health care. (Refer to pp. 12-14)

Click here to enter text.

## Collaborator

As Collaborators, physicians work effectively with other health care providers to provide safe, high-quality patient care. (Refer to pp. 15-16)

Click here to enter text.

## Lead er

As Leaders, physicians develop, in collaboration with other health care leaders, a vision of a high-quality health care system and take responsibility for effecting change to move the system toward the achievement of that vision. (Refer to pp. 17-18)

Click here to enter text.

## Health Advocate

As Health Advocates, physicians responsibly contribute their expertise and influence to improve health by working with the patients, communities, or populations they serve to determine and understand needs, develop partnerships, speak on behalf of others when needed, and support the mobilization of resources to effect change. (Refer to pp. 19-20)

Click here to enter text.

## Scholar

As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning, the teaching of others, the evaluation of evidence and other resources, and contributions to scholarship. (Refer to pp. 21-24)

Click here to enter text.

***7. Professional***

As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, commitment to the profession, profession-led regulation, and maintenance of personal health. (Refer to pp. 25-27).

Click here to enter text.

**AUTHORIZING SIGNATURES**

|  |  |
| --- | --- |
| **Name of Fellowship Supervisor:** | **Enter Name Here** |
| **Signature:** | **X** |
| **OR Insert Signature Image** |
| **Date of Signature: (MM/DD/YYYY)** | Click arrow, then use calendar |
| **Name of Fellowship Director/Department Program Director/Chair**  **(as appropriate):** | **Enter Name Here** |
| **Signature:** | **X** |
| **OR Insert Signature Image** |
| **Date of Signature: (MM/DD/YYYY)** | Click arrow, then use calendar |
| **Associate Dean, Postgraduate Medical Education** | Dr. Lisa Welikovitch, MD, FRCP |
| **Approval Signature:** | **X** |
| **OR Insert Signature Image** |
| **Date of Signature: (MM/DD/YYYY)** | Click arrow, then use calendar |

**Upon completion, please ensure this form gets uploaded to the** [**PGME SharePoint**](https://intranet.med.ucalgary.ca/pgmeduc/pgme/default.aspx) **site.**