

**POSTGRADUATE MEDICAL EDUCATION**

### *POSTGRADUATE MEDICAL TRAINING PROGRAM FRAMEWORK*

***FORM FOR CLINICAL FELLOWSHIPS – INTERNATIONAL SPONSOR***

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** |
| **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 | | | | | |

**GOVERNMENT OF CANADA’S LABOUR MARKET IMPACT ASSESSMENT (LMIA) INFORMATION**

For further information, please go to this [site](http://www.cic.gc.ca/english/department/acts-regulations/forward-regulatory-plan/new-fee-hiring.asp).

1. Explanation of how the job meets the requirements of the exemption being requested.  
   (Explain that there is no Canadian worker available to do the job, that there is a need for the foreign worker to fill the job and that hiring a Temporary Foreign Worker will not negatively affect the Canadian labour market)

Enter requirement explanation.

1. Address of the physical job location.

Enter address of physical job location.

1. Main duties of the job.

Enter job duties.

1. Experience/skills requirements of the job.

Enter experience required.

1. Wage (Canadian dollars) and the number of hours worked.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Amount**  **per hour** | **Amount**  **per year** | **Number of hours per day** | **Total number of hours per week** | **Total number of hours per month** |
| Enter | Enter | Enter | Enter | Enter |

1. List benefits provided.

|  |  |  |
| --- | --- | --- |
| **Vacation (number of business days per week):** | | Enter |
| **Other Benefits, specify:** | Enter | |

1. General Foreign Worker Information.

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name** (surname) as shown on passport | **Given Name (s)** | **Gender** | **Date of Birth**  (YYYY-MM-DD) |
| Enter | Enter | Choose | Click to Enter |
|  |  |  |  |
| **Country of Birth** | **Country of Residence** | **Citizenship** | **Passport Number** |
| Enter | Enter | Enter | Enter |

1. Compliance Fee Accounting Information.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Same as Above** | **Fund** | **Dept** | **Account** | **PC BU** | | **Project** | **Activity Code** | |
|  | Enter | Enter | Enter | | Enter | Enter | | Enter |

**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.**