UNIVERSITY OF MANITOBA | Rady Faculty of Health Sciences

Self-Directed Clinical Traineeship Application For Family Physicians

Please print clearly.

PERSONAL INFORMATION

1. Name: ____

2. Mailing Address: ____

   ____

3. Phone Number: ______________________ Fax Number: ______________________

4. Email Address: ____

5. Preferred communication: Email ____________________ Phone ____________________

6. Are you a Canadian Citizen? Yes ______ No _________

YOUR MEDICAL LICENSE

7. Are you licensed to practice medicine in Canada? Yes ______ No _______

8. In which province are you registered? ____

9. List any restrictions:____

10. Date first registered with current licensing body: ____

11. Current Licensing Authority registration number: ____

12. Current CMPA registration number: ____

13. Past licenses to practice medicine – please list all licensing authorities you have been registered with and the dates of the registration:

    ____

    ____

YOUR MEDICAL EDUCATION

14. Medical school attended plus year of graduation:

____

15. Postgraduate Medical Training – list all internship, residency, and/or fellowship experiences including dates and locations:

____

____

____

16. Other relevant training or experience:

____

____

CURRENT PRACTICE PROFILE

17. Approximately how many hours per week (excluding call) do you work? ______________________

18. Do you currently have hospital privileges? Yes _________ No ___________

    If so, at which hospital(s)? ____

19. What hospital will you require temporary hospital privileges? __________________________________

DEFINING YOUR LEARNING ELECTIVE

20. What type of educational experience are you requesting and for how long?

____

____

____

21. What are your personal learning objectives for the requested educational experience? Be as specific as possible.

    Dates available for your elective:
    a) First choice for dates: from ____________________________to____________________________

b) Alternate choice: from ___________________________to_______________________________

22. Please list the number of hours you will be in this traineeship: ______________

23. a.) Please identify a potential preceptor(s) to work with you during your elective. Please list the name(s) below.

____

____

____

b.) Have you already discussed your request and your objectives with this person(s) listed above and/or the department head?

Yes ______ No ______

Application Fee: $200

- First extension fee $50
- Second extension fee $100
- Further extensions are not permitted.

Refund Policy:
The application fee of $200 for the Self-Directed Clinical Traineeship is non-refundable and non-transferable.

If accepted, I agree to comply with the rules and regulations of the health authority and hospitals concerned, and with the rules and regulations governing the licensed physician self-directed clinical traineeship of the office of Competency and Assessment. I am aware that everyone involved in hospital activities must have a signed *Personal Health Information Act* pledge on file with the Winnipeg Regional Health Authority.

______________________________________ ______________________________________
(Signature of applicant) (Date)

Please complete, sign and return to:

CPD Medicine Program
Continuing Competency and Assessment, Rady Faculty of Health Sciences
University of Manitoba
260 Brodie Centre – 727 McDermot Avenue, Winnipeg, Manitoba R3E 3P5
Tel: (204)789-3238 ■ Fax: (204) 789-3911
Email: lenore.chipman@umanitoba.ca