**Application for Approval of Appointment**

**Of Postgraduate (Fellow)**

Use this form if you are a post-medical degree trainee who wishes to pursue further clinical or research training and will be licensed by the College of Physicians and Surgeons of British Columbia (“CPSBC”) in the Educational – Postgraduate (Fellow) class as described in CPSBC bylaw 2-26.

All applicants must be sponsored by either a Health Authority or University Department or Division subject to a Training Agreement.

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| 1. | **Applicant & Department/Division** | **Application Form**  The [Application for Approval of Appointment of Postgraduate (Fellow) Form](http://med-fom-pgme.sites.olt.ubc.ca/files/2015/01/Application-for-Approval-of-Appointment-of-Postgraduate-Fellow.docx) must be completed and signed by the following individuals, in the following order:   * Postgraduate (Fellow) * Training Supervisor * Department/Division Head * Health Authority Department/Division Head/Chief Officer of training site(s) |
| 2. | **Department/Division** | **Training Plan**  The Department/Division head must appoint a training supervisor. The training supervisor, in consultation with the Department/Division Head, must set out the goals and objectives of the fellowship training in writing, and a copy of the training plan must be submitted as a part of the application. |
| 3. | **Department/Division** | **Training Agreement**  All applicants must have a written Training Agreement with the sponsoring Health Authority or University setting out the terms and conditions under which the training is provided. A copy of the Training Agreement must be submitted as a part of the application. |
| 4. | **Applicant** | **Application Fee**  The applicant must pay a $500.00 non-refundable, non-transferable administrative fee. The administrative fee can be paid online or by UBC Internal Service Delivery Module (initiated by PGME). Extensions under six months do not require an administrative fee. |
| 5. | **Applicant**  **(as applicable)** | **SEAP Fee**  The applicant must pay a $5000.00 per year, non-refundable, non-transferable annual administrative fee. The administrative fee can be paid by UBC Internal Service Delivery Module (initiated by PGME) or online. |
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| **Department/Division** | | **Submission**  Once a completed application has been prepared, signatures obtained, and the fee(s) paid, the Department/Division is responsible for forwarding the application form to the Postgraduate Medical Education (PGME) Dean's Office for review and signature via Clinical Fellows Module (CFM). |
| **Postgraduate Medical Education (PGME)**  **Deans Office** | | **Signature**  Once a completed application has been submitted to the PGME Deans Office it will be reviewed and processed as appropriate. Applications signed by the Postgraduate Dean will be returned to the Department/Division. |

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| **Application Type** | |  | \*\*The Department/Division is responsible for obtaining licensure from the College of Physicians and Surgeons of British Columbia, as well as confirming that the Postgraduate (Clinical) Fellow has appropriate personal medical malpractice insurance and immigration/work permit documentation. SEAP must be declared at time of application \*\* |
| Postgraduate (Fellow) |  |  |
| Postgraduate (Fellow) with SEAP |  |  |
| Request for Extension < 6 months |  |  |
| Request for Extension > 6 months |  |  |

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| **Department/Division Contact Information** | |
| Name: | Jennifer Fox |
| Email Address: | Jennifer.fox@phsa.ca |
| Phone Number: | 604-875-2744 |

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| **Applicant Basic Information** | | | | | | | | | | | | | | | | | | | |
| Last Name: | Click here to enter text. | | | | | | | | First Name: | | | Click here to enter text. | | | | | | | |
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| Name (if different on medical degree): | | | | | | | Click here to enter text. | | | | | | | | M |  | F |  | X |  |
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| Date of Birth (m/d/yy): | | Click here to enter a date. | | | | | | | | Country of Birth: | | | | Click here to enter text. | | | | | |
| Citizenship: | | Click here to enter text. | | | | | | | | | | | | | | | | | |
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| Permanent Resident (Landed) | | | | |  | Work Permit | |  | |  | | | | | | | | | |
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| Email Address: | Click here to enter text. | | | | | | | | | | | | | | | | | | |
| Street Address: | Click here to enter text. | | | | | | | | | | | | | | | | | | |
| City/Province: | Click here to enter text. | | | | | | | | Postal Code: | | | Click here to enter text. | | | | | | | |
| Cell Phone: | Click here to enter text. | | | | | | | |  | | |  | | | | | | | |
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| **Medical Degree Information** | | | | | | | | | | | | | | | | | | | |
| University/College Name: | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| Medical Degree: | | | | Click here to enter text. | | | | | | | | | | | | | | | |
| Date: | | | | Click here to enter a date. | | | | | | | Country: | | Click here to enter text. | | | | | | |
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| **Medical Council of Canada Examinations** | | | | | | | | | | | | | | | | | | | |
| MCCEE: | | | Click here to enter text. | | | | | | | | Date: | | Click here to enter a date. | | | | | | |
| MCCQE Part I: | | | Click here to enter text. | | | | | | | | Date: | | Click here to enter a date. | | | | | | |
| LMCC#: | | | Click here to enter text. | | | | | | | | Date: | | Click here to enter a date. | | | | | | |

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| **Specialty Certifications** | | | | | | | | | | | | | | | | | |
| RCPSC Certification: | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
| If from UK – CCST (Certification of Specialist Training): | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
| American Board Certification: | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
| Other: | | Click here to enter text. | | | | | | Date: | | | Click here to enter a date. | | | | | | |
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| **Program Information** | | | | | | | | | | | | | | | | | |
| In what specialty or subspecialty will the fellow be training? | | | | | | Click here to enter text. | | | | | | | | | | | |
| Supervisor’s name | | | | | | Vi Ean Tan | | | | | | | | | | | |
| Supervisor’s email address | | | | | | vi.tan@cw.bc.ca | | | | | | | | | | | |
| Training site(s) during appointment: | | | Click here to enter text. | | | | | | | | | | | | | | |
| What is the anticipated length of training? | | | Click here to enter text. | | | | | | | | | | | | | | |
| Start Date (m/d/yy): | Click here to enter a date. | | | End Date (m/d/yy): | | | | | | | | | Click here to enter a date. | | | | |
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| Is your proposed program of study realistically capable of completion in two years or less? | | | | | | | | | | No | |  | | Yes | |  |  |
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| In no, please explain: | | | Click here to enter text. | | | | | | | | | | | | | | |
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| Have you previously been registered and licensed by the  College of Physicians and Surgeons of British Columbia? | | | | | No | |  | | Yes | |  | | Date: | | Click here to enter a date. | | |
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| **COVID-19 Vaccine Certification:** | | | | | | | | | | | | | | | | | | |
| **\* Please attach a copy of vaccination certificate to this application form or declare the vaccination status in this** [**link**](https://ubc.ca1.qualtrics.com/jfe/form/SV_23qsGpqmwNboqoe)**. Fellows must ensure they are able to comply with the**[*PHO directive*](https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-hospital-and-community-vaccination-status-information-preventive-measures.pdf)**in order to start their training.** | | | | | | | | | | | | | | | | | | |

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| **Source of Funding for Appointment** | | | | | |
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|  | Ministry of Health - Alternative Payments Section | | | | $Click here to enter text. |
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|  | Ministry of Health - Mental Health Division | | | | $Click here to enter text. |
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|  | Hospital Operating Budget (account code:Click here to enter text.) | | | | $Click here to enter text. |
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|  | Hospital Department (account code:Click here to enter text. | | | | $Click here to enter text. |
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|  | Hospital Foundation | | | | $Click here to enter text. |
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|  | Vancouver Health Department | | | | $Click here to enter text. |
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|  | Military Funding | | | | $Click here to enter text. |
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|  | Country as Sponsor | | | | $Click here to enter text. |
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|  | Societies or Organizations | | | | $Click here to enter text. |
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|  | Charities or Religious Organizations | | | | $Click here to enter text. |
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|  | Grant Funded Fellowships | | | | $Click here to enter text. |
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|  | Self-Funded | | | | $Click here to enter text. |
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|  | | Other (please indicate) | Click here to enter text. |  | $Click here to enter text. |

\*Please append a current curriculum vitae outlining current postgraduate training\*

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| **Signature Page** | | |
| It is acknowledged that:  With the exception of applicants in the Royal College of Physician and Surgeons (“Royal College”) Specialty Examination Affiliate Program (“SEAP”) clinical fellowship training does not qualify toward establishing eligibility for specialty or sub-specialty certification by the Royal College of Physicians and Surgeons (“Royal College”). Upon completion of the training Clinical Fellows will not be eligible to write the Royal College examination.  Applicants who wish to have the Training considered for eligibility for specialty or subspecialty certification by the Royal College SEAP must declare their intention at the time of the application and prior to the commencement of Training. Applicants who fail to declare their intention will not receive a Final In-Training Evaluation (“FITER”) or equivalent sign-off by University of British Columbia, Faculty of Medicine, Post-Graduate Medical Education Associate Dean (“PGME Dean”) for submission to the Royal College.  The College of Physicians and Surgeons of British Columbia (“CPSBC”) does not recognize SEAP as meeting any requirements for licensure in British Columbia under its bylaws.  The training time and experience acquired in this appointment will not be used towards establishing eligibility for Canadian licensure, certification by the College of Family Physicians of Canada, or specialty or subspecialty certification by the Royal College of Physicians and Surgeons of Canada.  The applicant must have the appropriate educational license granted by the CPSBC. It is the applicant’s responsibility to meet the criteria established by the CPSBC for licensure. The English language proficiency requirements as set out by the College of Physicians and Surgeons of British Columbia must be met.  CPSBC bylaws 2-26(4) and (5) provide that Postgraduate (Fellow) registration may be granted for a period of up to two years to provide an applicant with an opportunity to acquire further postgraduate training in the applicant’s specialty or sub-specialty. An extension for a further one year [for a maximum of three years of Postgraduate (Fellow) registration] may only be granted in exceptional or extenuating circumstances, upon request from the Associate or Assistant Dean, Office of Postgraduate Medical Education, UBC Faculty of Medicine. | | |
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| Signature of Applicant: | Print Name: |  |
| Date: |  |
| Signature of Training Supervisor: | Print Name: |  |
| Date: |  |
| Signature of UBC Department/Division Head: | Print Name: |  |
| Date: |  |
| Signature of Health Authority Department Head/Division Head/Chief Officer: | Print Name: |  |
| Date: |  |
| Signature of UBC Associate/Assistant Dean,  Postgraduate Medical Education: | Print Name: |  |
| Date: |  |

SIGNATURE ADDENDUM PAGE

For use when training occurs at multiple sites and additional signatures are required

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| Addendum To: Application for Approval of Appointment of Postgraduate (Fellow) | |
| Name of the applicant: | |
| Training Program: | |
| Training Duration: | |
| Signatures for additional training site | |
| Signature of Health Authority Training Supervisor: | Print Name: |
| Date: |
| Signature of Health Authority Department Head/Division Head/Chief Officer: | Print Name: |
| Date: |
| Signatures for additional training site (if applicable) | |
| Signature of Health Authority Training Supervisor: | Print Name: |
| Date: |
| Signature of Health Authority Department Head/Division Head/Chief Officer: | Print Name: |
| Date: |