



Cardiovascular MR Training Registration Form

Stephenson Cardiovascular MR Centre
Suite 0700, Special Services Building, Foothills Medical Centre
1403 – 29th Street NW
Calgary, AB T2N 2T9

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Return Registration Form to Dr. Silke Friedrich, Program Coordinator

This information is collected under the authority of the Freedom of Information and Protection of Privacy Act (FOIP), the Income Tax Act (Canada) and the Government Organization Act (Alberta). It will form part of the student/resident record, and is required to register you in your training program, record your progress in the academic and administrative units, including the Calgary Regional Health Authority (CRHA). Specific data elements will be disclosed to the federal and provincial governments to meet reporting elements. All data is confidential and will be used and disclosed in accordance with privacy legislation. Only aggregate data without personal identifiers are considered public information.

SURNAME		FIRST NAME		GIVEN NAMES		SIN Number		U of C ID Number			
SURNAME		NAME ON MD CERTIFICATE (if different) GIVEN NAMES				MAIDEN NAME (if different)		DATE OF BIRTH YYYY MM DD		PLACE OF BIRTH	
SEX <input type="checkbox"/> M <input type="checkbox"/> F		E-MAIL ADDRESS				FAX NUMBER		IMMIGRATION STATUS <input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Landed Immigrant <input type="checkbox"/> Work Visa <input type="checkbox"/> Other (Please Specify) _____			
IF NOT CANADIAN CITIZEN, PROVIDE COUNTRY						DATE LANDED YYYY MM DD					
CURRENT ADDRESS STREET		CITY		PROVINCE		POSTAL CODE		TELEPHONE NUMBER		EFFECTIVE UNTIL YYYY MM DD	
PERMANENT ADDRESS (if different) STREET		CITY		PROVINCE		POSTAL CODE		TELEPHONE NUMBER			
EDUCATION		INSTITUTION & LOCATION				FROM (year)	TO (year)	DEGREE OR QUALIFICATION			
MD or Equivalent											
Postgraduate Training (Residencies)											
Other (Please Specify)											
POSTGRADUATE TRAINING PROGRAM REQUESTED: (Residency, Fellowship, Elective)		FIELD OF MEDICINE EXPECTED TO BECOME QUALIFIED IN:		RESEARCH YEAR <input type="checkbox"/> YES <input type="checkbox"/> NO		ANNUAL REGISTRATION PERIOD: Beginning YYYY MM DD		Ending YYYY MM DD		EXPECTED COMPLETION DATE OF ENTIRE PROGRAM: YYYY MM DD	
PREVIOUS CERTIFICATION IN CANADA College of Family Physicians (CFPC) <input type="checkbox"/> NO <input type="checkbox"/> YES FIELD/SPECIALTY _____ The Royal College of Physicians of Canada (RCPS) <input type="checkbox"/> NO <input type="checkbox"/> YES FIELD/SPECIALTY _____ Collège des médecins du Québec (CMQ) <input type="checkbox"/> NO <input type="checkbox"/> YES FIELD/SPECIALTY _____				PREVIOUS CERTIFICATION IN USA <input type="checkbox"/> Not Applicable <input type="checkbox"/> Surgery <input type="checkbox"/> Family Medicine <input type="checkbox"/> Other (Please Specify) _____ <input type="checkbox"/> Internal Medicine _____							
HAVE YOU PASSED THE MCCQE (Medical Council of Canada Qualifying Examination)? LMCC received before 1992 <input type="checkbox"/> YES Part I (Check one only) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Awaiting examination results Part II (Check one only) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Awaiting examination results						IF YOU GRADUATED FROM A MEDICAL SCHOOL OUTSIDE CANADA OR USA, HAVE YOU PASSED THE MCCEE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A					
DO YOU HAVE A LICENCE TO PRACTICE MEDICINE IN ONE OR MORE PROVINCES OR TERRITORIES OF CANADA? (Being on an education register is not a license to practice medicine) <input type="checkbox"/> YES <input type="checkbox"/> NO						RETURN FROM PRACTICE (Re-entry) Have you already spent one year or more in unsupervised medical practice in Canada either private practice or a salaried position? <input type="checkbox"/> YES <input type="checkbox"/> NO					
APPLICANT SIGNATURE:											
UNIVERSITY USE ONLY											
TRAINING	PAY	CAPER RANK	EQUIV. RANK	YEAR 1	Different Anniversary Date	ELECTIVE	FULL TIME				
						<input type="checkbox"/> YES	<input type="checkbox"/> YES <input type="checkbox"/> NO				
PAID BY <input type="checkbox"/> CRHA <input type="checkbox"/> OTHER:											
PRIMARY SITE <input type="checkbox"/> FH <input type="checkbox"/> PLC <input type="checkbox"/> RVG <input type="checkbox"/> ACH <input type="checkbox"/> Rural: <input type="checkbox"/> Other:											
UNIVERSITY SIGNATURE:						DATE:					