

Eastern Regional Medical Education Program

Teaching Application

Full Name:			
Medical Facility:			
Mailing Address:			
Telephone Number:		Fax Number:	
E-mail:			
Teaching Specialty:	<input type="checkbox"/> Fam. Med <input type="checkbox"/> ER Med <input type="checkbox"/> Int. Med <input type="checkbox"/> Gen. Surg <input type="checkbox"/> OBS <input type="checkbox"/> PAEDS <input type="checkbox"/> Other (please specify)		
Medical Licence CPSO #:		Date of M.D.:	
Medical School:		Postgrad. University:	
* SIN #:		** Preferred Affiliation: <input type="checkbox"/> Ottawa U <input type="checkbox"/> Queen's U	
Additional Qualifications:	<input type="checkbox"/> CCFP <input type="checkbox"/> Other (specify)		
Clinical Interests:			
Years in Practice:		Hobbies:	
Preferred Length of Placement:	<input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months		Comments:
Current Hospital:			
Name & Tel. # of Department Chief:			
DECLARATION OF APPLICANT: Having read the policy regarding the duties of a preceptor, I solemnly declare and warrant that my past training and experience has been of such a nature and duration that I consider myself competent and capable of undertaking a teaching and supervisory role. I further declare that I have read and will abide by the CPSO Supervision Guidelines and PAIRO agreement. <u>PLEASE ATTACH A RECENT CV.</u>			
Signed: (Applicant)		Date:	
Name of Nominating Physician:		Phone Number:	
DECLARATION OF NOMINATING PHYSICIAN: It is my belief that the physician making this application is competent to teach and will be an excellent addition to the Eastern Regional Medical Education Program.			
Signed: (Nominating MD)		Date:	
PLEASE RETURN BY FAX TO ERMEP OFFICE (613) 267-8060			
PLEASE NOTE:			
<i>* We require your SIN number for T4A purposes only.</i>			
<i>** The choice of affiliation is used for insurance purposes.</i>			