eastern regional medical education program
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TEACHING APPLICATION

FULL NAME:
MEDICAL FACILITY:
MAILING ADDRESS:
TELEPHONE NUMBER: **FAX NUMBER:**
E-MAIL ADDRESS:

TEACHING SPECIALTY: ☐ FM ☐ EM ☐ Int. Med ☐ Gen. Surg ☐ OBS ☐ PAED ☐ Other *(please specify)*

MEDICAL LICENCE CPSO #: **DATE OF M.D.:**

MEDICAL SCHOOL: **POSTGRAD UNIVERSITY:**

***SIN # OR CORPORATION #:**
PLEASE CIRCLE APPROPRIATE SUFFIX TO YOUR CRA CORP # **RC 0001** **RP 0001**

****PREFERRED AFFILIATION:** ☐ OTTAWA U ☐ QUEEN'S U

ADDITIONAL QUALIFICATIONS: ☐ CCFP ☐ OTHER *(please specify)*

CLINICAL INTERESTS:

YEARS IN PRACTICE:

PREFERRED LENGTH OF PLACEMENT: ☐ 1 MONTH ☐ 2 MONTHS

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.*

Please attach a recent CV.

SIGNATURE: **DATE:**

PLEASE RETURN TO ERMEP 613-267-8060 FAX # OR EMAIL jennifershuttleworth@ermep.com

PLEASE NOTE:
****We require your SIN # or Corporation # for T4A purposes only.***
*****The choice of affiliation is used for insurance purposes.***