

## NL Health Services Application for Medical Resident Bursary

Eastern Rural

Eastern Urban

Central

Western

Labrador-Grenfell

Application deadline: January 31<sup>st</sup> of the academic year of application.

Medical resident bursaries are only available in the last two years of residency.

### Part 1: To be completed by the applicant.

#### APPLICANT INFORMATION

|   |                |              |
|---|----------------|--------------|
| Surname:  | Given Name:    | Initial:     |
| Social Insurance Number:  | Date of birth: | (DD/MM/YYYY) |
| (Canada Revenue Agency regulations require your Social Insurance Number for taxation purposes.) |                |              |
| Mailing Address:  |                |              |
| Home Province:  |                |              |
| Telephone Number:   | Email Address: |              |

#### EDUCATION INFORMATION

|                          |                              |              |
|--------------------------|------------------------------|--------------|
| Medical School Attended: | Graduation Date:             | (DD/MM/YYYY) |
| Residency Program:       |                              |              |
| Location of Residency:   | Anticipated Completion Date: |              |

#### CONFIRMATION OF PREVIOUS FUNDING

|   |    |
|---|----|
| Has the applicant previously received funding under this or any other program offered by the Department of Health and Community Services? i.e. Undergraduate Medical Student Bursary, Physician Signing Bonus, etc. |    |
| Yes   | No |
| Has the applicant previously received a signing bonus or bursary from NL Health Service?  |    |
| Yes   | No |
| If you answered "Yes" to any of the above questions, please provide details and amounts.  |    |

**Part 2: To be completed by NL Health Services**

**COMMUNITY OF PRACTICE INFORMATION**

|  |                                     |
|--|-------------------------------------|
| Physician Type: Family Medicine  |                                     |
| Specialist   | Area of Specialty or Sub-specialty: |
| Name of Community/Facility of Full-Time Practice:  |                                     |
| What services will be provided by the applicant during the service agreement? (Check all that apply) |                                     |
| Day Clinics  | Traveling Clinics                   |
| Emergency Department Coverage  | Inpatient Services                  |
| Practice start date:   | (DD/MM/YYYY)                        |

**SIGNATURES**

**Please ensure the following documentation is attached:**

Letter of confirmation of the practice location from NL Health Services

Letter of offer from a practice in the practice community or from NL Health Services outlining the full range of services appropriate to the specialty, and reflective of the needs of NL Health Services. Services may include, but are not limited to, emergency room coverage, day clinics, evening clinics, weekend clinics, obstetrics, institutions services and/or inpatient services OR letter of intent to hire/practice specifying that some combination of the services listed above will be required and determined prior to first day of practice.

**Declaration by the Applicant and NL Health Services:**

I certify that all information given on this application is complete and true to the best of my knowledge.

I authorize that the Government of Newfoundland and Labrador may collect information in this application and exchange that information as it considers necessary for the purposes of approving bursaries.

I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate repayment of current bursaries and disqualification from receiving future incentives. Collection, use or disclosure of personal information is in accordance with privacy legislation.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NL Health Services Signature: \_\_\_\_\_ Date: \_\_\_\_\_