TRAVELLING RESIDENCY PROGRAM APPLICATION

APPLICANT INFORMATION

Surname:_____ Given Name:_____

Current Mailing Address:_____

Telephone: _____ Email: _____

Undergraduate Medical Education Institution: _____

RESIDENCY INFORMATION

Current Residency Institution: _____

Current Program:_____

Transfer Institution:_____

Transfer Program:_____

Current PGY:_____ Years of Training Required:_____

ESTIMATED COST

Please provide a yearly estimate of all costs associated with the fellowship (i.e. salary, benefits, administrative fees, etc.).

DECLARATION BY APPLICANT

I certify that all information given on this application is complete and true to the best of my knowledge. 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 funding and disqualification from receiving future incentives. The Department of Health and Community Services has my consent to the collection, use and disclosure of my personal information in accordance with the Access to Information and Protection of Privacy Act, 2015.

Personal information on this form is being collected for evaluation of eligibility criteria. This information is being collected under the authority of section 61(c) of the Access to Information and Protection of Privacy Act. By signing this form you have consented to the collection and sharing of this information between the Medical Services Division of the Department of Health and Community Services and the Newfoundland and Labrador Health Services for the purposes of approving the Travelling Residency application. Should you have any questions about the collection, use or disclosure of your personal information, please contact MedServicesPrograms@gov.nl.ca.

Applicant Signature:_____ **Date:**_____

Please include the following documents along with your application:

- ☐ Two confidential reference letters sent directly to the Medical Services Division, Department of Health and Community Services at MedServicesPrograms@gov.nl.ca.
- ☐ Letter from the Director of the program being sought indicating acceptance to the program.
- ☐ Letter of commitment from NL Health Services indicating the need for the specialty and availability of a position following completion of training.

PLEASE RETURN COMPLETED APPLICATIONS VIA MAIL OR EMAIL TO:
Medical Services Division
Department of Health and Community Services
1st Floor, West Block, Confederation Building
P.O. Box 8700, St. John's, NL A1B 4J6
MedServicesPrograms@gov.nl.ca