

## Application Form

### Educational Fellowship for Practising Physicians

Complete below in full and use as the cover page of your electronic and paper copy of your application

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<b>Fellowship Applicant</b>				
Name of Applicant	First Name	Middle Initial	Last Name	
Contact Information	Telephone Number	Email Address		
Residential Address	Street Address and Suite/Unit			
	City/Town	ON	Postal Code	
Current Practice Address	Street Address and Suite/Unit			
	City/Town	ON	From (Date)	
Previous Practice Location (if applicable)	Street Address and Suite/Unit			
	City/Town	Province	From (Year)	To (Year)
<b>Degrees and Diplomas Held</b>				
Degree	Date	Institution		
<b>Post-Graduate Training Experience Overview</b>				

<b>Present Type of Practice Overview</b> <i>(complete below, space will expand as needed)</i>		
<b>Description of Training Program</b> <i>(complete below, space will expand as needed)</i>		
<b>Duration of Training Program:</b>	<b>Program Start Date:</b>	
<b>Program Institution</b>	Name and Department of Institution	
	Location	Department Head / Chair at Program Institution
<b>Have you applied for or received funds from any other source for this training program?</b>  Yes___ No___ If yes, provide details below:		
<b>Will you be in receipt of salary or practice income for the period of training?</b>  Yes___ No___ If yes, provide details below:		
<b>Name of sponsoring group from whom a letter of endorsement is attached to this application:</b> <i>(note: not required for research methodology training but must be included for all other requests. Also note the signatory of letter should be the head / chair of the department in which the applicant works)</i>		
<b>Will the application of the acquired skill or knowledge require the use of new equipment?</b>  ___No ___ Yes (If yes, please attached to application the required letter from the hospital administrator indicating the equipment is installed or on order for early delivery)		

### Details of Funds Requested

Expenses	Amount
Course Fees	
Travel	
Accommodations	
Meals	
<b>Other (please specify in detail below)</b>	
•	
•	
<b>TOTAL REQUESTED</b>	

## Signature

In signing this application, I agree that if a fellowship is awarded I agree to provide the PSI Foundation with a written report on the program I have undertaken. Upon completion of the training program I intend to return to practise in the community in which I am currently practising and if my training is in research methodology I agree to conduct the research within my current community. I further agree that if I accept financial assistance for the above training from any other source I will the Foundation of such assistance and agree to refund the amount awarded by the Foundation if requested in writing to do so.

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**Signature**

**Date Signed**

Applications will be considered for support of physicians who have undertaken training courses that commenced up to **three months prior to the time the application is considered at a meeting of the Foundation's Grants Committee.** For the meeting dates of the Grants Committee please see below or contact the Foundation at [psif@psifoundation.org](mailto:psif@psifoundation.org) .

### 2009 – 2010 Grants Committee Meeting Dates

December 2, 2009

March 2, 2010

June 9,2010

The submission must be sent to the Foundation in two parts:

- Email a file of the complete application package to [psif@psifoundation.org](mailto:psif@psifoundation.org)

**AND**

- Mail or courier one paper copy of the complete application package including signature and letter of endorsement to the Foundation's offices as below:

Physicians Services Inc Foundation  
5160 Yonge Street, Suite 1006  
Toronto, ON M2N 6L9

Telephone: 416.226.6323