# 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

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Fellowship Applicant** | | | | | | | | | |
| 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) |
| **Degrees and Diplomas Held** | | | | | | | | | |
| **Degree** | | **Date** | | | | **Institution** | | | |
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| **Post-Graduate Training Experience Overview** | | | | | | | | | |
|  | | | | | | | | | |
| **Present Type of Practice Overview** *(complete below, space will expand as needed)* | | | | | | | | | |
|  | | | | | | | | | |
| **Description of Training Program** *(complete below, space will expand as needed)* | | | | | | | | | |
|  | | | | | | | | | |
| **Duration of Training Program:** | | | | **Program Start Date:** | | | | | |
| **Program Institution** | Name and Department of Institution | | | | | | | | |
| Location | | | | Department Head / Chair at Program Institution | | | | |
| **Have you applied for or received funds from any other source for this training program?**  **Yes\_\_\_ No\_\_\_ If yes, provide details below:** | | | | | | | | | |
| **Will you be in receipt of salary or practice income for the period of training?**  **Yes\_\_\_ No\_\_\_ If yes, provide details below:** | | | | | | | | | |
| **Name of sponsoring group from whom a letter of endorsement is attached to this application:**  *(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)* | | | | | | | | | |
| **Will the application of the acquired skill or knowledge require the use of new equipment?**  **\_\_\_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** |  |
| **Other (please specify in detail below)** |  |
|  |  |
|  |  |
| **TOTAL REQUESTED** |  |

# Signature

In signing this application, I agree that if a fellowship is awarded I will 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 practice in the community in which I am currently practicing 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 inform the Foundation of such assistance and agree to refund the amount awarded by the Foundation if requested in writing to do so.

**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.**

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**Submission:**

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

### Contact Us

Please contact us at 416.226.6323 or by email at [psif@psifoundation.org](mailto:psif@psifoundation.org) to discuss any questions you may have about submitting an application for funding.