



**APPLICATION
FOR CLINICAL TRAINING**

Information to be submitted 30 days before Elective

Name		Student ID #	
Street	City	Prov	PC
email	Phone	Cell	
Emergency Contact Name	Emergency Contact Number		

College of Family Physicians of Canada (CCFP)	<input type="checkbox"/> PGY1	<input type="checkbox"/> PGY3
	<input type="checkbox"/> PGY2	

Fellow of the Royal College of Surgeons of Canada (FRCSC)	<input type="checkbox"/> PGY1	<input type="checkbox"/> PGY4
	<input type="checkbox"/> PGY2	<input type="checkbox"/> PGY5
	<input type="checkbox"/> PGY3	

Fellow of the Royal College of Physicians of Canada (FRCPC)	<input type="checkbox"/> PGY1	<input type="checkbox"/> PGY4
	<input type="checkbox"/> PGY2	<input type="checkbox"/> PGY5
	<input type="checkbox"/> PGY3	

University	
<input type="checkbox"/> Med 1st yr.	<input type="checkbox"/> Med 2nd yr.
<input type="checkbox"/> Med 3rd yr.	<input type="checkbox"/> Med 4th yr.

License to Practice	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CPSO #		
Category of license		

Malpractice	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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CMPA#		Category of coverage	
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If you have no CMPA or do not attend Queens University, attach a letter from your University stating the type of coverage you have

COMMUNICABLE DISEASE SCREENING FOR CLINICAL PLACEMENTS
*****Incomplete or outdated information will delay placement start date*****
Proof of Immunization MUST accompany your application

Tuberculosis (Mantoux)	Step 1 Date:		Date Read:		Result:	
	Step 2 Date:		Date Read:		Result:	

All positive converters must have a chest x-ray	Date Read: <input type="text"/>	Result: <input type="text"/>
Date of recent 5tu/PPD (within the last year) Mantoux	Date Read: <input type="text"/>	Result: <input type="text"/>

<u>Tetanus/Diphtheria/Pertusis/Polio</u>	Date (y/m/d)	<input type="text"/>
<u>Varicella: (Chicken Pox)</u>	Date of Immunization and/or titre results (y/m/d)	<input type="text"/>
<u>Measles</u>	Dates of Immunizations if possible , titre results mandatory (y/m/d)	<input type="text"/>
<u>Mumps</u>	Dates of Immunizations if possible , titre results mandatory (y/m/d)	<input type="text"/>
<u>Rubella</u>	Dates of Immunizations if possible , titre results mandatory (y/m/d)	<input type="text"/>
<u>Hepatitis B</u>	Dates of Immunizations or titre results (y/m/d)	<input type="text"/>
Influenza Seasonal	Date <input type="text"/>	Influenza H1N1 Date <input type="text"/>
N95 Mask Size:	<input type="text"/>	Date Last Fitted (y/m/d) <input type="text"/>
Core Rotation Requested (select 1 per application)	<input type="text"/>	Supervising Physician @ BGH <input type="text"/>
Elective Requested (select 1 per application)	<input type="text"/>	Supervising Physician @ BGH <input type="text"/>
Student Signature	<input type="text"/>	Start Date <input type="text"/> End Date: <input type="text"/>

This section to be completed by Supervising Physician only

Supervising Physician to indicate which of the following requirements is needed

<input type="checkbox"/> Orientation	<input type="checkbox"/> Computer training	<input type="checkbox"/> PACS training	<input type="checkbox"/> Computer access	<input type="checkbox"/> Health records and Dictaphone training
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All Medical Trainees who will be working with front line staff and/or patients in Hospital are required to wear a BGH ID Badge.	<input type="checkbox"/> YES
<i>Will your student require an ID Badge</i>	<input type="checkbox"/> NO

Physician Signature	<input type="text"/>	DATE	<input type="text"/>
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Fully completed forms are to be submitted 30 days in advance of rotation

Student Checklist:

All Required Information has been completed

Applicant has signed the application form

Applicant has ensured **PROOF** of immunization is attached

Click Submit Form button and select appropriate email program type, then:

- 1. Select 'Send Data File' to email form then print/fax signature page to 613-345-8336 OR**
- 2. Select 'Print Form', sign and fax to 613-345-8336 OR**
- 3. Print and Mail to: Fay Garvin c/o 75 Charles Street, Brockville, Ontario K6V 1S8**