***University of Toronto Department of Medical Imaging – Nuclear Medicine Residency Program***

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| --- | --- | --- | --- | --- | --- |
| ***Residency start date:***  July \_\_\_\_\_\_\_\_\_\_  (year) | | | ***Residency end date:***  June \_\_\_\_\_\_\_\_\_\_  (year) | | |
| ***Last name*** | | | ***First Name*** | | |
| ***Citizenship*** | | | ***Date of Birth*** | | |
| ***Languages spoken (fluently)*** | | | | | |
| ***Current position*** | | | | | |
| ***Program*** | | | | | |
| ***Two years*** | Nuclear Medicine | | | | |
| ***Funding***  Are you applying for funded position or will you be arranging your own funding? | | | | Funded  Self-funded  Sponsored | |
| ***Address*** | | ***Telephone***  ***(work)*** | | | |
| ***Telephone***  ***(home)*** | | | |
| ***Fax*** | | | |
| ***E-mail*** | | | |
| ***Radiology certification***  Are you fully qualified or certified in Diagnostic Radiology? | | | | | |
| yes date certified:  certifying body:  no anticipated date of certification:  certifying body: | | | | | Are you…  ABR\* certified?  ABR\* eligible?  neither  not applicable/don’t know  *\* American Board of Radiology* |

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| ***Professional Certification***  (licences, specialty certification, etc.)  Certificate  (e.g., FRCP, FRCR, general licence, etc.) | Certifying Body  (e.g., Royal College of P&S of Canada, CPSO, etc.) | Date registered |
|  |  |  |
| ***Radiology training***  Program name/location | Details | Date |
|  |  |  |
| ***Medical School***  University | Program/degree | Date |
|  |  |  |

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| ***Professional Certification***  Please request your referees to send letters of reference directly to the Nuclear Medicine Program Director via e-mail or fax. Letters should not accompany this application and they should not be sent to the Program Director’s hospital address. One of your referees should be your Radiology Residency Program Director (or equivalent individual). If your Program Director cannot provide a reference, please attach an explanation. An application is not complete until three letters of reference have been received separately by the University of Toronto Department of Medical Imaging administrative office. | | |
| ***Name of referee*** | ***Address*** | ***Telephone number*** |
| **1. Radiology Residency Program Director:** |  |  |
| **2.** |  |  |
| **3.** |  |  |

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

**Complete pages 1 through 3 and return with:**

* completed declaration (page 4)
* applicant’s letter
* curriculum vitae
* copy of medical degree

to

Dr. R. Vali

c/o Jennifer Morris

Email: nucmed.program@utoronto.ca

***Declaration (must be completed by all applicants)***

1. Have you been convicted of a criminal offence for which a pardon has not been granted?

yes \* no

1. Have you ever been convicted of any other offence (for which a pardon has not been granted) that may affect your eligibility for Ontario Educational registration (i.e., your eligibility for an Ontario educational licence)?

yes \* no

1. Are there charges pending for an alleged offence that my affect your eligibility for Ontario Educational registration?

yes \* no

1. Have you ever been subject to a disciplinary hearing of a medical licensing authority?

yes \* no

1. Have you ever been denied licensure by a medical licensing authority or had such licensure revoked or limited?

yes \* no

1. Have you ever been disciplined, suspended, or dismissed from an undergraduate or postgraduate educational program?

yes \* no

**\* If you answered ‘yes’ to any of the above, please provide details:**

I hereby certify that the information given on this form and attachments is true and complete. I understand that I shall be disqualified if information is withheld or false information has been provided and that any appointment already made or in progress will be cancelled and all credit revoked.

Date: Signature:

Name (print):