



**Division of Gynecologic Oncology**

**FELLOWSHIP APPLICATION FORM**

**Deadline: March 31, 2021**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
 (Family name) (First name) (Middle name) (mm/dd/yyyy)

**Mailing Address:** \_\_\_\_\_  
 (Number and Street name) (Apt. #)  
 \_\_\_\_\_  
 (City/Town/State) (Postal/ZIP Code) (Country)

**Business Tel. No:** \_\_\_\_\_ **Pager No:** \_\_\_\_\_ **Home Tel. No:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
 (Street name and number) (City/Town/State)  
 \_\_\_\_\_  
 (City/Town/State) (Postal Code)

**Citizenship:** \_\_\_\_\_ **Country of Origin:** \_\_\_\_\_

**Current Status:** Resident  Fellow  Practicing Specialist   
**Do you currently have a licence to practice Medicine in the Province of Ontario? :** YES  NO

**EDUCATION**

Name of all Universities Attended (including current)	Official Name of Degree/Diploma/Residency	Years of Attendance From To	Degree/Diploma/Residency Awarded

## **INITIAL application requirements that MUST accompany application**

For graduates of an acceptable medical school <b><u>Outside Canada</u></b> And the United States of America (USA) <b>Please check off and enclose with application:</b>	Graduates of Accredited Medical Schools <b><u>In Canada</u></b> Or the United States of America (USA) <b>Please check off and enclose with application:</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Up-to-date detailed curriculum vitae Curriculum Vitae (CV) must include, at the beginning:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Applicant's country of birth and citizenship</li> <li><input type="checkbox"/> Date of birth</li> <li><input type="checkbox"/> Current employment status</li> <li><input type="checkbox"/> E-mail and residential addresses.</li> </ul>               Time gaps of training and/or professional appointments must be clarified under separate cover.             </li> <li><input type="checkbox"/> Letter confirming funding support (if being sponsored)</li> <li><input type="checkbox"/> 3 letters of reference</li> <li><input type="checkbox"/> Copy of Medical Degree (from University of graduation(with English translation if NOT in English)</li> <li><input type="checkbox"/> Specialist Certificate (copy) from accepted certification board or equivalent, stating the applicant is a certified specialist (with English translation<sup>1</sup> if NOT in English). For applicants who are in their final year of training: <b>Out of Canada:</b> provide an official letter/certificate from the Certification Board that               <ol style="list-style-type: none"> <li>1) confirms the applicant is enrolled in a training program for specialist certification and</li> <li>2) States the expected date of certification.</li> </ol> <b>In Canada:</b> provide a letter from the Program Director that               <ol style="list-style-type: none"> <li>1) confirms the applicant is enrolled in a training program for specialist certification, and</li> <li>2) States the expected date of certification.</li> </ol> </li> <li><input type="checkbox"/> A personal letter stating applicant's goals and objectives for fellowship</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Up-to-date detailed curriculum vitae</li> <li><input type="checkbox"/> Letter confirming sponsorship support (if applicable)</li> <li><input type="checkbox"/> 3 letters of reference</li> <li><input type="checkbox"/> Legible photocopy of a certificate or letter confirming specialty certification. OR if enrolled in residency program, letter from Program Director confirming status in Residency Program.</li> <li><input type="checkbox"/> Copy of Medical Degree</li> <li><input type="checkbox"/> A personal letter stating applicant's goals and objectives for fellowship</li> </ul>

### **1“TRANSLATIONS”**

**All documents and letters not written in the English or French language must be accompanied by certified English or French Translations. All translations must be certified by one of the following:**

**(i) A Certified Member of the Association of Translators and Interpreters of Ontario (ATIO). To find a certified translator,**

**Please visit their website: [www.atio.on.ca](http://www.atio.on.ca). Translations completed by a certified member of the equivalent**

**Association of Translators and Interpreters in another Canadian province/territory are also acceptable.**

**(ii) A Canadian Embassy overseas or a foreign embassy or consular office in Canada authorized to certify translations.**

**Translations sent by the medical school are acceptable provided they are dated and stamped by the medical school to verify the**

**contents and are received directly from the medical school with the original language document. Translations not meeting the above requirements are not acceptable.” (College of Physicians and Surgeons of Ontario, Applications for IMG Clinical Fellows)**

\* If you wish clarification of any of the above, please contact Gigi Lacanlale at 416-946-4043 or e-mail [grezafe.lacanlale@uhn.ca](mailto:grezafe.lacanlale@uhn.ca)

\* **Additional documentation required following receipt of Job Offer from Fellowship Director**

Outside Canada and the USA	In Canada or the USA
<ul style="list-style-type: none"> <li><input type="checkbox"/> Work Permit processing fee: University of Toronto administrative processing fee is \$160 CDN in the form of: –Credit card authorization – (Appendix 1 from the Fellowship Application Form.). <b>OR</b> –Cheque / money order made payable to the University of Toronto.</li> <li><input type="checkbox"/> Medical Council of Canada Evaluating Exam if appointment is for more than 2 years</li> <li><input type="checkbox"/> Copy of TOEFL IBT** results that demonstrate: TOEFL IBT Passing score: 93, including a minimum of 24 on the speaking section. (**TOEFL Services: P.O. Box 6151, Princeton , NJ 08541, USA Tel: (609) 771-7100, Fax: (609) 771-7500, Email: toefl@ets.org, website: <a href="http://www.toefl.org">www.toefl.org</a></li> </ul>	<p>Copy of Medical Transcript</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Immunization Record</li> </ul>

\_\_\_\_\_  
(Applicant's name - please print)

\_\_\_\_\_  
(Applicant's signature)

\_\_\_\_\_  
(Date)

Please email completed application form to: [grezafe.lacanlale@uhn.ca](mailto:grezafe.lacanlale@uhn.ca)

OR

Please forward other required documents to:

**Gigi Lacanlale**  
**Princess Margaret Cancer Centre**  
**610 University Avenue, OPG Wing 6<sup>th</sup> Flr, 6W-369**  
**Toronto, Ontario M5G 2M9**  
**CANADA**

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