APPLICATION FROM PROPOSED **TRAINEE**

FOR SURGEON SCIENTIST TRAINING PROGRAM

PROGRAM: **MSc** ☐ **PhD** ☐ **Other** [Click here and type] → _____

NAME OF TRAINEE: _____

DATE FOR STARTING RESEARCH: _____

NAME OF PROPOSED SUPERVISOR WHO HAS AGREED TO ACT AS YOUR SUPERVISOR:

_____

NAME OF EXTERNAL AGENCY TO WHOM YOU WILL APPLY FOR FUNDING:

_____

NAME OF INSTITUTE / GRADUATE DEPARTMENT TO WHICH YOU HAVE APPLIED OR WILL APPLY FOR ADMISSION AS A GRADUATE STUDENT IN THE SCHOOL OF GRADUATE STUDIES: (It is the responsibility of the student to complete this application process prior to starting date of research.)

_____

NAME OF UNIVERSITY DIVISION CHAIR WITH WHOM YOU HAVE DISCUSSED THIS APPLICATION AND WHOM YOU HAVE ASKED TO FORWARD A LETTER OF SUPPORT:

_____

WHY DO YOU WISH TO JOIN THE SURGEON SCIENTIST TRAINING PROGRAM?
(Maximum - 150 words)

DESCRIPTION OF RESEARCH TO BE PERFORMED: (Maximum - 150 words)

DEADLINE: MAY 15th

SEND APPLICATION TO:

Dr. Michael G. Fehlings, Vice Chair Research
c/o Val Cabral, Research Program Manager
Department of Surgery Research Office
University of Toronto
Stewart Building
149 College Street, 5th Floor, Room 503J
Toronto, ON Canada M5T 1P5
tel: 416-978-8909
Email: val.cabral@sickkids.ca

Trainee's Signature _____ Date _____

**University DIVISION Head Signature _____ Date _____

****University DIVISION Head signature denotes approval of financial support of student according to Department guidelines.**

APPLICATION FROM PROPOSED SUPERVISOR

FOR SURGEON SCIENTIST TRAINING PROGRAM

Click on the gray shaded (blue boxes) to make your selection. Tab to next selection.

PROGRAM: **MSc** ☐ **PhD** ☐ **Other** [Click here and type] → _____

NAME OF PROPOSED TRAINEE: _____

DATE FOR STARTING RESEARCH: _____

NAME OF PROPOSED SUPERVISOR:

_____

BRANCH OF GRADUATE SCHOOL IN WHICH YOU ARE A MEMBER:

_____

CURRENT GRANTS: (Indicate agency, title of grant, amounts for current and subsequent years, and whether sufficient funds are available for research to be performed by trainee.)

LOCATION OF PROPOSED RESEARCH: (Indicate whether sufficient space is available for the trainee's research.)

PROPOSED SOURCE(S) OF PERSONAL SALARY SUPPORT FOR SURGEON SCIENTIST:

DESCRIPTION OF RESEARCH TO BE PERFORMED BY TRAINEE: (Maximum - 150 words)

DEADLINE: MAY 15th

SEND APPLICATION TO:

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c/o Val Cabral, Research Program Manager
Department of Surgery Research Office
University of Toronto
Stewart Building
149 College Street, 5th Floor, Room 503J
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tel: 416-978-8909
Email: val.cabral@sickkids.ca

Supervisor's Signature

Date

University of Toronto

Department of Surgery
UNIVERSITY OF TORONTO

NEW SURGEON SCIENTIST
Contact Information

Trainee's NAME	
Home Address	
Home Phone Number	
Resident Cell Number	
E-Mail Address	
Supervisor's Name	
Supervisor's Office Phone Number	
Supervisor's E-mail Address	
Lab Address	
Lab Phone Number	

SURGEON SCIENTIST TRAINING PROGRAM

APPLICATION CHECKLIST

TRAINEE'S NAME:				
PROGRAM:	☐ **MSc**	☐ **PhD**	**Other**	[Click here and type] → _____

SUBMITTED THE FOLLOWING WITH APPLICATION:	CHECK APPROPRIATE BOX
2. Supervisor's Application	☐ enclosed to follow
3. CV of Trainee	☐
4. CV of Supervisor	☐
5. Letter of support from University Division Chair Letter of support from Division Program Director	☐ ☐
6. Clinician Investigator Program Application - c/o CIP Office, Faculty of Medicine, University of Toronto, Ste. 2366 Medical Sciences Bldg., Toronto M5S 1A8	☐ has been sent to CIP Office directly ☐ will be sent directly to CIP Office

RETURN THIS COMPLETED CHECKLIST WITH YOUR APPLICATION