

CI Society – Talecris Fellow Training Program in Immunodeficiency

The CI Society-Talecris Fellow Training Program provides financial aid to trainees in Canadian fellowship programs who wish to expand their education in immunodeficiency disorders. The intent of the program is to support pediatricians, allergists and other specialists who plan to practice in Canada upon completion of their studies.

Specific arrangements must be made with the home and host institution Training Program Directors before applying. Only after full agreement of the rotation by all parties can a fellow apply to the CI Society-Talecris Fellow Training Program.

Financial support for lodging and transportation will be calculated on a weekly basis with a maximum of 4 weeks per fellow (per fellowship). Expenses will be reimbursed once proof has been provided. Applicants must be enrolled in a Royal College of Physicians and Surgeons training stream.

Application Check List:

Please ensure the following documentation for your application to the CI Society-Talecris Fellow Training Program is enclosed in your submission.

- Application form**
- Current Curriculum vitae**
- Letter of Support from Program Director of Home Institution**
- Letter of acceptance from Program Director of the Host Institution**
- Copy of your active Work Permit Visa (if applicable)**
- Copy of Medical certification/degree**
- Copy Pediatric Specialty Certification (if applicable)**
- Proof of all expenses**

All applications should be emailed to fellows@cisociety.com

Canadian Immunodeficiency Society
CI Society-Talecris Fellow Training Program
P.O. Box 38540
3299 Bayview Avenue
Toronto, ON. M2K 2Y5
Tel: 416-964-3434
Fax: 416-964-6594
Email: fellows@cisociety.com

Thank you for your interest in our program. We look forward to your application submission.



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APPLICANT INFORMATION

Full Name: _____ Date: _____

Surname *Given Name(s)* *M.I.* *DD/MM/YYYY*

Address: _____

Street Address *Apartment/Unit #*

City *Province* *Postal Code* *Country*

Phone: _____ Fax: _____

Mobile: _____ Social Insurance No: _____

E-mail Address: _____

Is your mailing address the same as above? YES NO If no please provide below.

Address: _____

Street Address *Apartment/Unit #*

City *Province* *Postal Code* *Country*

Please Indicate the Host Institute you propose to attend: _____ **Start Date:** _____

(DD/MM/YYYY)

BUDGET

Please note the maximum funding term of the CI Society-Talecris Fellow Training Program is **4 weeks** as an immunology fellow. **Proof of all expenses must be included in this application.** Funding will be provided for:

1. Lodging (maximum \$325/wk) or transportation at a distance greater than 2 hours by car, one way.
2. Flights to a maximum of \$500

Approval is contingent on CI Society-Talecris Fellow Training Program funding availability.

Expense 1:

Transportation: \$ _____ **OR** Lodging \$ _____

Details of expense: _____

Expense 2:

Flight: \$ _____ Details: _____



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LICENSING:

Are you currently licensed to practice medicine in the Province of Ontario/Quebec? YES NO

If yes, please provide one of the following:

A:

_____ *Independent Practice License Number*

_____ *Expiry Date (DD/MM/YYYY)*

B:

_____ *Ontario/Quebec Postgraduate Certificate of Registration Number*

_____ *Expiry Date (DD/MM/YYYY)*

Have you ever been subject to any action or license suspension by any licensing authority? YES NO

If yes, please provide details in an accompanying letter.

LANGUAGES and QUALIFYING EXAM

The following section must be completed by graduates of medical schools outside Canada and the USA.

Native language spoken :

Language of instruction at medical school: _____

Other languages spoken: _____

Please indicate whether you have passed the following examinations. If so please provide documentation.

MCCEE (Medical Council of Canada Evaluating Exam):	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Score: _____
TOEFL (Test of English as a Foreign Language):	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Score: _____
TSE (Test of Spoken English)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Score: _____

EDUCATION AND TRAINING

Medical School:

Institution Name: _____

Address: _____

_____ *City*

_____ *Country*

Graduation Date: _____

DD/MM/YYYY

Degree Earned: _____



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Internship:

Institution Name: _____

Address: _____

City

Country

Internship Type: _____

Start Date: _____

End Date: _____

DD/MM/YYYY

DD/MM/YYYY

Postgraduate Residency and Fellowship:

Position:	Institution:	Address:	Start Date: <i>(DD/MM/YYYY)</i>	End Date: <i>(DD/MM/YYYY)</i>

Specialty Certification:

Area of Specialty	Date Received: <i>(DD/MM/YYYY)</i>



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References

Training Program Director – Home Institution

Full Name: _____ Phone: _____
Institute: _____
Address: _____

Street Address *Apartment/Unit #*

City *Province* *Postal Code* *Country*

Training Program Director – Host Institution

Full Name: _____ Phone: _____
Institute: _____
Address: _____

Street Address *Apartment/Unit #*

City *Province* *Postal Code* *Country*

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to funding, I understand that false or misleading information in my application or interview may result in my release, exclusion to any funding and the repayment of any funding received.

Signature: _____ Date: _____