MIDDLESEX HOSPITAL ALLIANCE
Strathroy Middlesex General Hospital/Four Counties Health Services

REGISTRATION FOR POSTGRADUATE CLINICAL TRAINING AND OBSERVERSHIPS

LAST NAME: _____ FIRST NAME: _____

MEDICAL UNIVERSITY
STUDENT REGISTRATION NO: _____

ADDRESS

_____

_____

CELL PHONE: _____ EMAIL: _____

UNIVERSITY: The University of Western Ontario

AFFILIATED HOSPITAL: _____

TRAINING PROGRAM: _____

CATEGORY/LEVEL: _____
(e.g.: pgy1, fellow, med student)

CPSO #: _____

CMPA #: (or other (1)) _____

START DATE (of rotation): _____

FINISH DATE (of rotation): _____

ELECTIVE (yes or no): _____

IN CASE OF EMERGENCY PLEASE CALL : _____

TEL: _____

SUPERVISOR/CONTACT PERSON: _____
(MHA Medical Staff Physician)

Return form to: Anita Fernandes
Administrative Assistant
SMGH Site
Anita.fernandes@mha.tvh.ca or fax (519)-245-0366

(1) This could be through the affiliated hospital.