APPLICATION
SCHULICH SCHOOL OF MEDICINE
WESTERN UNIVERSITY
COMBINED MD/PhD PROGRAM

Application Deadline: 1-December

_____ OMSAS NUMBER.	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms OTHER (SPECIFY) _____	_____ LEGAL SURNAME	_____ FIRST NAME MIDDLE NAME
MAILING ADDRESS APT. # NO. & STREET		**HOME (PERMANENT) ADDRESS** APT. # NO. & STREET	
CITY PROVINCE		CITY PROVINCE	
COUNTRY	POSTAL CODE	COUNTRY	POSTAL CODE
AREA CODE & PHONE NUMBER	EMAIL ADDRESS		AREA CODE & PHONE NUMBER
COUNTRY OF CITIZENSHIP	LEGAL STATUS IN CANADA ☐ CANADIAN CITIZEN ☐ PERMANENT RESIDENT		

ACADEMIC BACKGROUND

DEGREE	NAME OF DISCIPLINE	INSTITUTION/UNIVERSITY	COUNTRY	YEAR

RESEARCH EXPERIENCE

PROJECT TITLE	UNIVERSITY/PROGRAM	SUPERVISOR/INSTITUTE	YEAR

REFERENCES

References from TWO individuals who will critically assess the candidate=s research experience and potential, as well as the ability to work productively under the time constraints of the MD/PhD Program. Referee's assessments should be sent to the *MD/PhD Program, Research Office, Schulich School of Medicine & Dentistry, Clinical Skills Building, Room 2720, Western University, N6A 5C1, Canada*.

REFEREE'S NAME		REFEREE'S NAME	
TITLE		TITLE	
APT. # NO. & STREET		APT. # NO. & STREET	
CITY PROVINCE		CITY PROVINCE	
COUNTRY	POSTAL CODE	COUNTRY	POSTAL CODE
AREA CODE & PHONE NUMBER		AREA CODE & PHONE NUMBER	
E-MAIL ADDRESS		E-MAIL ADDRESS	

RETURN APPLICATION TO:
The MD/PhD Program, c/o Stacey Bastien
Office of the Dean, Schulich School of Medicine & Dentistry
Clinical Skills Building, Room 2720
Western University, London, ON N6A 5C1