

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

Application Deadline: *1-December

_____ OMSAS NUMBER.	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> 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 <input type="checkbox"/> CANADIAN CITIZEN <input type="checkbox"/> 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
 Western University
 Clinical Skills Building, Room 2716
 1151 Richmond Street
 London, ON N6A 5C1
 or via email at: mdphd@schulich.uwo.ca*

* IF DECEMBER 1ST FALLS ON A SATURDAY OR SUNDAY, THE DUE DATE WILL BE MOVED TO THE MONDAY.