

**APPLICATION FOR the CLINICIAN INVESTIGATOR PROGRAM (CIP)**  
*Western University*  
**Schulich School of Medicine & Dentistry**

*Please fill out the entire application neatly and obtain ALL signatures.*

NAME: \_\_\_\_\_  
*Surname* *First name* *Initial*

UWO Student #: \_\_\_\_\_

SIN # (ONLY IF no student no.): \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_

Status in Canada (if NOT Canadian Citizen):

\_\_\_ Permanent resident                      \_\_\_ Student Visa  
\_\_\_ Employment Authorization              \_\_\_ Other

CURRENT ADDRESS: \_\_\_\_\_  
*No. & Street* *City*

\_\_\_\_\_  
*Province* *Postal Code* *Email Address (please use Western email)*

Current Phone#: Work (\_\_\_) \_\_\_\_\_ Home (\_\_\_) \_\_\_\_\_

**DEADLINE:**  
January 9, 2023 to begin the following July 1

Clinician Investigator Program at Western University is a Royal College certified program to support senior residents during graduate training.

Applicants must have completed their core years and must be planning to undertake a graduate program at Western University. This can be in either the M.Sc. or Ph.D. track.

I, \_\_\_\_\_, hereby apply for a position in the Clinician Investigator Program at the Schulich School of Medicine & Dentistry, Western University.

**PREMEDICAL EDUCATION:**

University \_\_\_\_\_  
Dates of Attendance \_\_\_\_\_  
Program & Degree Awarded \_\_\_\_\_

**MEDICAL EDUCATION:**

Medical School \_\_\_\_\_  
Dates of Attendance \_\_\_\_\_  
Degree Awarded \_\_\_\_\_

**POSTGRADUATE TRAINING**

*Please list all postgraduate training appointments only in chronological order from date of graduation.*

**Residency**

Residency Program \_\_\_\_\_

Dates of Attendance \_\_\_\_\_

Program Director \_\_\_\_\_

**Fellowship**

Dates of Attendance \_\_\_\_\_

University Program \_\_\_\_\_

Program Director \_\_\_\_\_

**List Teaching and Research positions you have held since graduation:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you hold an Ontario General License to practice Medicine? Yes \_\_\_ No \_\_\_ License # \_\_\_\_\_

Do you hold a valid Ontario Educational License to practice Medicine? Yes \_\_\_ No \_ License # \_\_\_\_\_

Which of the following examinations or qualifications have you passed?

a) Medical Council of Canada Qualifying Examination (MCCQE)

▪ MCCQE Part I yes / no

▪ MCCQE Part II yes / no

▪ Are you a licentiate of the Medical Council of Canada? Registration # \_\_\_\_\_

b) Medical Council of Canada Evaluating Examination (MCCEE)

c) Visa Qualifying Examination (VQE)

d) Federation of Licensing Authorities Examination (FLEX)

e) Foreign Medical Graduate Exam in Medical Science (FMGEMS)

f) National Board of Medical Examiners Parts I, II (NBME)

Previous College Certification and/or Board Examination:

Certifying Body	Specialty	Country	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List certificates, awards, scholarships, memberships, etc. and the year in which they were obtained.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACHMENTS**

The following attachments must be submitted in order for application to be considered:

- Curriculum Vitae (including a summary of previous research experience)
- Copies of publications giving authors and titles, etc.
- Medical School Transcripts
- Letter of Support from Program Director (current program)
- Proposed Plan of Research (maximum 2 pages), including start and end dates
- Proposed Graduate Studies Supervisor and Graduate Studies Committee
- Three letters of reference are required from faculty who have had a meaningful responsibility for your medical education or research supervisor(s). (Applications will not be considered until these letters of reference, which must be mailed directly and independently by the referee, have been received.) Please list name, title, address and telephone number of your referees.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*I certify that the above answers are accurate and complete.*

Signature of Resident: \_\_\_\_\_

Date: \_\_\_\_\_

To apply, please complete the application form and send the form plus supporting documentation to the CIP Committee Office by **Monday, January 9<sup>th</sup>, 2023** at:

Research Office c/o Stacey Bastien  
 Schulich School of Medicine & Dentistry  
 Room 2716, Clinical Skills Building  
 Western University  
 1151 Richmond Street  
 London, Ontario N6A 5C1  
 t. 519-661-2111 ext. 87908 f. 519-931-5220

<p><b>Successful applicants will receive a Conditional Offer Letter and a Memo of Understanding from the CIP Office and a Letter of Appointment from the Postgraduate Medical Education Office.</b></p>
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e. [cip@schulich.uwo.ca](mailto:cip@schulich.uwo.ca)

**FACULTY APPROVAL**

\_\_\_\_\_, Dr. J. Lewis, CIP Director

\_\_\_\_\_, Dr. L. Champion, Associate Dean, PGME Office