

DEFINING YOUR LEARNING ELECTIVE

19. What type of educational experience are you requesting and for how long?

*Please see our information sheet for more
information on the Self-Directed Learning Clinical
Elective program*

Thank you for your interest.

20. What are your personal learning objectives for the requested educational experience?
Be as specific as possible.

Self-Directed Learning

**A Clinical Elective
Program
for
Licensed Physicians**

21. If you have identified a potential preceptor to work with during your elective, please list the name(s) below? Have you already discussed your request and your objectives with this person and/or the Department Head?

Please mail or deliver your completed and signed
application form to :

Ms. Pat Kolody
Office Manager
Continuing Medical Education
S203-750 Bannatyne Avenue
Winnipeg, Manitoba
R3E 0W3

PLEASE PRINT OR TYPE

1. Name: _____

2. Mailing Address: _____

3. Phone Number: _____

4. Fax Number: _____

5. Email Address: _____

Should we communicate with you by email or fax?

Email Fax

6. Are you a Canadian Citizen?

Yes No

YOUR MEDICAL LICENSE

7. Are you licensed to practice medicine in Canada?

Yes No

8. Which province are you registered in?

List any restrictions.

9. Date first registered with current licensing body.

10. Current Licensing Authority registration number

11. Current CMPA registration number

12. Past licenses to practice medicine – please list all licensing authorities you have been registered with and the dates of the registration.

YOUR MEDICAL EDUCATION

13. Medical School attended + year graduation:

14. Postgraduate Medical Training – list all internship, residency, and/or fellowship experiences including dates and location.

15. Other relevant training or experience.

CURRENT PRACTICE PROFILE

16. How many hours per week (excluding call) do you work approximately?

17. Do you currently have hospital privileges?

Yes No

If so, at which hospital(s)?

18.. Dates available for your elective:

a) First choice for dates:

from _____

to _____

b) Alternate choice:

from _____

to _____

QUESTIONS 19 -21 ON OTHER SIDE →

If accepted, I agree to comply with the rules and regulations of the Health Authority and Hospitals concerned, and with the rules and regulations governing the licensed physician self-directed learning program of the Office of Continuing Medical Education. I am aware that everyone involved in hospital activities must have a signed *Personal Health Information Act* pledge on file with the Winnipeg Regional Health Authority.

(signature of applicant)

(date)