

**APPLICATION FROM PROPOSED TRAINEE
FOR SURGEON SCIENTIST TRAINING PROGRAM**

PROGRAM: MSc PhD Other [\[Click here and type\]](#) → _____

NAME OF TRAINEE: _____

DATE FOR STARTING RESEARCH: _____

NAME OF PROPOSED SUPERVISOR WHO HAS AGREED TO ACT AS YOUR SUPERVISOR:

NAME OF EXTERNAL AGENCY WHERE YOU WILL APPLY FOR FUNDING:

NAME OF INSTITUTE / GRADUATE DEPARTMENT TO WHICH YOU HAVE APPLIED OR WILL APPLY FOR ADMISSION AS A GRADUATE STUDENT IN THE SCHOOL OF GRADUATE STUDIES: (It is the responsibility of the student to complete this application process prior to starting date of research.)

NAME OF UNIVERSITY DIVISION CHAIR WITH WHOM YOU HAVE DISCUSSED THIS APPLICATION AND WHOM YOU HAVE ASKED TO FORWARD A LETTER OF SUPPORT:

WHY DO YOU WISH TO JOIN THE SURGEON SCIENTIST TRAINING PROGRAM?
(Maximum - 150 words)

Application from Proposed TRAINEE
for Surgeon Scientist Training Program

DESCRIPTION OF RESEARCH TO BE PERFORMED: (Maximum - 250 words)

DEADLINE: MAY 15th

SEND APPLICATION TO: **Dr. Michael G. Fehlings, Vice Chair Research**
c/o Val Cabral, Research Program Manager
Department of Surgery Research Office
University of Toronto
Stewart Building
149 College Street, 5th Floor, Room 503J
Toronto, ON Canada M5T 1P5
tel: 416-978-8909
Email: val.cabral@sickkids.ca

Trainee's Signature

Date

**University DIVISION Head Signature

Date

****University DIVISION Head signature denotes approval of financial support of student according to Department guidelines.**

APPLICATION FROM PROPOSED SUPERVISOR

FOR SURGEON SCIENTIST TRAINING PROGRAM

Click on the gray shaded (blue boxes) to make your selection. Tab to next selection.

PROGRAM: MSc PhD Other [\[Click here and type\]](#) → _____

NAME OF PROPOSED TRAINEE: _____

DATE FOR STARTING RESEARCH: _____

NAME OF PROPOSED SUPERVISOR:

BRANCH OF GRADUATE SCHOOL IN WHICH YOU ARE A MEMBER:

CURRENT GRANTS: (Indicate agency, title of grant, amounts for current and subsequent years, and whether sufficient funds are available for research to be performed by trainee.)

LOCATION OF PROPOSED RESEARCH: (Indicate whether sufficient space is available for the trainee's research.)

PROPOSED SOURCE(S) OF PERSONAL SALARY SUPPORT FOR SURGEON SCIENTIST TRAINEE:

DESCRIPTION OF RESEARCH TO BE PERFORMED BY TRAINEE: (Maximum - 250 words)

DEADLINE: MAY 15th

SEND APPLICATION TO: **Dr. Michael G. Fehlings, Vice Chair Research**
c/o Val Cabral, Research Program Manager
Department of Surgery Research Office
University of Toronto
Stewart Building
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tel: 416-978-8909
Email: val.cabral@sickkids.ca

Supervisor's Signature

Date



**Department of Surgery
UNIVERSITY OF TORONTO**

**NEW SURGEON SCIENTIST
Contact Information**

Trainee's NAME	
Home Address	
Home Phone Number	
Resident Cell Number	
E-Mail Address	
Supervisor's Name	
Supervisor's Office Phone Number	
Supervisor's E-mail Address	
Lab Address	
Lab Phone Number	



SURGEON SCIENTIST TRAINING PROGRAM

APPLICATION CHECKLIST

TRAINEE'S NAME:			
PROGRAM:	<input type="checkbox"/> MSc	<input type="checkbox"/> PhD	Other [Click here and type] → _____

SUBMITTED THE FOLLOWING WITH APPLICATION:	CHECK APPROPRIATE BOX
2. Supervisor's Application	<input type="checkbox"/> enclosed to follow
3. CV of Trainee	<input type="checkbox"/>
4. CV of Supervisor	<input type="checkbox"/>
5. Letter of support from University Division Chair Letter of support from Division Program Director	<input type="checkbox"/> <input type="checkbox"/>
6. Clinician Investigator Program Application - c/o CIP Office, Faculty of Medicine, University of Toronto, Ste. 2366 Medical Sciences Bldg., Toronto M5S 1A8	<input type="checkbox"/> has been sent to CIP Office directly <input type="checkbox"/> will be sent directly to CIP Office

**RETURN THIS COMPLETED CHECKLIST
WITH YOUR APPLICATION**