439 University Avenue – Suite 848
Toronto, ON, M5G 1Y8
Tel: (416) 964-3434
Email: **contactus@immunodeficiency.ca**

Immunodeficiency Canada
Fellows Training Program in Immunodeficiency

The Immunodeficiency Canada Fellows Training Program provides financial aid to trainees in Canadian Allergy and Clinical Immunology training programs who wish to expand their education in immunodeficiency disorders. The intent of the program is to support Allergy and Clinical Immunology trainees who plan to practice in Canada upon completion of their studies. In order to be eligible for this fellowship, trainees must be traveling at distances greater than a 100km radius from the host institution.

Specific arrangements must be made with the home and host institution Training Program Directors before applying. Only after full agreement of the rotation by all parties can a fellow apply to the Immunodeficiency Canada Fellows Training Program.

Financial support for lodging and transportation will be calculated on a weekly basis with a maximum of 4 weeks per fellow (per fellowship). Expenses will be reimbursed once proof has been provided. Applicants must be enrolled in a Royal College of Physicians and Surgeons training stream.

Application Check List:
Please ensure the following documentation for your application to the Immunodeficiency Canada-Grifols Fellow Training Program is enclosed in your submission.

- ☐ **Application form**
- ☐ **Current Curriculum vitae**
- ☐ **Letter of Support from Program Director in Allergy and Clinical Immunology of Home Institution**
- ☐ **Letter of acceptance from Program Director of the Host Institution**
- ☐ **Copy of Medical certification/degree**
- ☐ **Proof of all expenses**

All applications should be emailed to contactus@immunodeficiency.ca

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Thank you for your interest in our program. We look forward to your application submission.

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APPLICANT INFORMATION

Full Name: _____ Date: _____

Surname *Given Name(s)* *M.I.* *DD/MM/YYYY*

Address: _____

Street Address *Apartment/Unit #*

_____

City *Province* *Postal Code* *Country*

Phone: _____ Fax: _____

Mobile: _____ Social Insurance No: _____

E-mail Address: _____

Is your mailing address the same as above? YES ☐ NO ☐ If no please provide below.

Address: _____

Street Address *Apartment/Unit #*

_____

City *Province* *Postal Code* *Country*

Please Indicate the Host Institute you propose to attend:
(SickKids Toronto, Montreal Children's, Sainte Justine)

_____

Start Date:

_____
(*DD/MM/YYYY)*

BUDGET

Please note the maximum funding term of the Immunodeficiency Canada-Grifols Fellow Training Program is **4 weeks** as an immunology fellow. **Proof of all expenses must be included in this application.** Funding will only be provided for trainees traveling at distances greater than a 100km radius from the host institution. Applicable expenses include:

1. Lodging (maximum $325/wk) **or** transportation
2. Flights to a maximum of $500

Approval is contingent on Immunodeficiency Canada-Grifols Fellow Training Program funding availability.

Expense 1:

☐ Transportation: $ _____ **OR** ☐ Lodging $ _____

Details of expense: _____

Expense 2:

Flight: $ _____ Details**:** _____

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LICENSING:

Are you currently licensed to practice medicine in the Province of Ontario/Quebec? YES ☐ NO ☐

If yes, please provide one of the following:

A:

_____ _____
Independent Practice License Number *Expiry Date (DD/MM/YYYY)*

B:

_____ _____
Ontario/Quebec Postgraduate Certificate of Registration Number *Expiry Date (DD/MM/YYYY)*

Have you ever been subject to any action or license suspension by any licensing authority? YES ☐ NO ☐

If yes, please provide details in an accompanying letter.

LANGUAGES and QUALIFYING EXAM

The following section must be completed by graduates of medical schools outside Canada and the USA.

Native language spoken :

Language of instruction at medical school: _____

Other languages spoken: _____

Please indicate whether you have passed the following examinations. If so please provide documentation.

MCCEE (Medical Council of Canada Evaluating Exam): YES ☐ NO ☐ Score: _____

TOEFL (Test of English as a Foreign Language): YES ☐ NO ☐ Score: _____

TSE (Test of Spoken English) YES ☐ NO ☐ Score: _____

EDUCATION AND TRAINING

Medical School:

Institution Name:

Address: _____

_____
City *Country*

Graduation Date: _____ Degree Earned: _____
DD/MM/YYYY

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Internship:

Institution Name: _____

Address: _____

_____

City *Country*

Internship Type: _____ Start Date: _____ End Date: _____

DD/MM/YYYY *DD/MM/YYYY*

Postgraduate Residency and Fellowship:

Position:	**Institution:**	**Address:**	**Start Date:** *(DD/MM/YYYY)*	**End Date:** *(DD/MM/YYYY)*

Specialty Certification:

Area of Specialty	**Date Received:** *(DD/MM/YYYY)*

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References

Training Program Director – Home Institution

Full Name: _____ Phone: _____

Institute: _____

Address: _____

Street Address *Apartment/Unit #*

City *Province* *Postal Code* *Country*

Training Program Director – Host Institution

Full Name: _____ Phone: _____

Institute: _____

Address: _____

Street Address *Apartment/Unit #*

City *Province* *Postal Code* *Country*

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to funding, I understand that false or misleading information in my application or interview may result in my release, exclusion to any funding and the repayment of any funding received.

Signature: _____ Date: _____