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:

NAMES OF EXTERNAL AGENCIES TO WHOM 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 and/or PROGRAM DIRECTOR 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)

DESCRIPTION OF RESEARCH TO BE PERFORMED: (Maximum - 150 words)

DEADLINE: OCTOBER 15

SEND APPLICATION TO:

Dr. Michael Fehlings, Vice Chair Research
c/o Val Cabral, Research Program Manager
Department of Surgery Research Office
PGCRL, 16-9-702, 686 Bay Street
Toronto, ON M5G 0A4
Phone: 416-813-2178
E-Mail: 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 SSTP 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:

DESCRIPTION OF RESEARCH TO BE PERFORMED BY TRAINEE: (Maximum - 150 words)

DEADLINE: OCTOBER 15

SEND APPLICATION TO:

Dr. Michael Fehlings, Vice Chair Research
c/o Val Cabral, Research Program Manager
Department of Surgery Research Office
PGCRL, 16-9-702, 686 Bay Street
Toronto, ON M5G 0A4
Phone:416-813-2178
E-Mail: val.cabral@sickkids.ca

Supervisor's Signature

Date

SURGEON SCIENTIST TRAINING PROGRAM

APPLICATION CHECKLIST

TRAINEE'S NAME:

PROGRAM: ☐ **MSc** ☐ **PhD** **Other** [Click here and type] →

SUBMITTED THE FOLLOWING WITH APPLICATION:	CHECK APPROPRIATE BOX
1. Trainee's Application	☐
2. Supervisor's Application	☐
3. CV of Trainee	☐
4. Letter of support from University Division Chair Letter of support from Division Program Director	☐ enclosed ☐ to follow

DEADLINES

SURGEON SCIENTIST TRAINING PROGRAM APPLICATION DEADLINE – OCTOBER 15

HEALTH POLICY, MANAGEMENT & EVALUATION APPLICATION DEADLINE – NOVEMBER 15

INSTITUTE OF MEDICAL SCIENCE APPLICATION DEADLINE – APRIL 1

OTHER GRADUATE SCHOOL APPLICATION DEADLINES – PLEASE CHECK U OF T WEBSITE

RETURN THIS COMPLETED CHECKLIST WITH YOUR APPLICATION

University of Toronto

Department of Surgery
UNIVERSITY OF TORONTO

NEW SURGEON SCIENTIST
Contact Information

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