NEW RESIDENT INFORMATION PROFILE
2023/2024 ACADEMIC YEAR

PRINT CLEARLY USING BLOCK LETTERS. **Dalhousie ID (if known):** _____

Name in which you are registered with the Faculty of Medicine:

_____
Surname Given Name Middle Name

Name as it appears on your medical degree (M.D. or equivalent) is:

_____
Surname Given Name Middle Name

Permanent Home Address:

Street: _____ City: _____

Province: _____ Country: _____ Postal Code: _____ Phone: _____

Cell Number: _____ Email Address: _____

Local Address in Nova Scotia, New Brunswick or Prince Edward Island (if known):

Effective Date: _____

Street: _____ City: _____

Province: _____ Country: _____ Postal Code: _____ Phone: _____

Cell Number: _____ Email Address: _____

Date of Birth: _____ **Place of Birth:** _____
(YY/MM/DD)

Marital Status: _____ **Gender (Male/Female/Other):** _____

Please indicate the province where you received your high school diploma. _____

Return from Practice (Re-entry): ____ Yes ____ No

Legal Status in Canada: _____ I am a Canadian Citizen
_____ I am a Permanent Resident. If you have not previously supplied your Permanent Resident papers, please send information to our office.
_____ I am in Canada on an Employment Authorization
_____ I am in Canada on a Student Authorization
_____ OTHER – SPECIFY _____

Country of Citizenship: _____**Visa Expiry Month:** _____

Hospital Credentials Committees require we collect the following information on an annual basis.
Have you already spent one year or more in unsupervised medical practice in Canada in either private practice or in a salaried position? ____ YES ____ NO

Type of License _____ **Province** _____

POSTGRADUATE TRAINING:
Answers to each of the following questions are required. Failure to answer or leaving the section blank will result in a delay or potential denial of the credentialing and licensing process, with a subsequent delay in the start of your training.

a) Are you a member of the Department of National Defense (DND)? YES _____ NO _____

b) If you have been registered or are currently registered in any other postgraduate training program, please note this information here.

Type of Preceptorship, Internship or Residency: _____ Dates (From/To): _____

Institution: _____

Address: _____

Program Director or Preceptor: _____

Reasons for leaving position: _____

Reasons for any interruption in training (incl. length): _____

c) Have you ever had an application for medical licensure rejected?

YES _____ NO _____ If yes, please explain. _____

_____

d) Are you presently or have you ever been subject to an allegation, complaint or investigation for any reason whatsoever by a medical licensing authority?

YES _____ NO _____ If yes, please explain. _____

_____

e) Have you ever had your Medical License revoked?

YES _____ NO _____ If yes, please explain. _____

_____

f) Is there any event, circumstance, condition or matter not disclosed in your answers to the preceding questions in respect to you character, conduct, competence or capacity that might be an impediment to your application for Postgraduate training or licensure?

YES _____ NO _____ If yes, please explain. _____

_____

g) Have you had an alcohol or substance abuse problem?

YES _____ NO _____ If yes, please explain. _____

_____

We wish to assure that you have all the assistance that can be provided to help with the stresses of postgraduate training. Trainees who require accommodation for either program training issues or modifications to the physical workplace, please contact our office directly.

Whom should we contact in case of emergency during your training? This information will be shared with your home program.

Next of Kin _____
Address _____
City _____ Province _____ Postal Code _____
Relationship to Self _____Phone _____

For all Surgical Trainees: The Competency Committee of the program to which you have been accepted requires the results of your Principles of Surgery (POS) Exam in order to ensure that you are eligible for promotion during your training. Please indicate you agree to release your POS results when they become available by signing below.

I hereby agree to release my POS results to my program's Competence Committee.

Signature: _____ Date: _____

The information above will be used to update the Dalhousie University, Faculty of Medicine, Postgraduate Medical Education database for the purposes of managing your participation in a Dalhousie University residency training program.

Some information will be provided to other organizations as required by your paymaster, by licensing bodies, by malpractice insurance organizations, by certification and licensing examination bodies, by Maritime Resident Doctors to verify your status and manage benefit payments, by Doctors Nova Scotia, and other organizations who have legitimate requirements to verify postgraduate residency training information, including, but not limited to, CAPER (described below).

CAPER is a national database established for the purpose of compiling accurate and consistent national statistics concerning post-M.D. training in Canada. The identity of individuals to whom the information provided to CAPER relates will be maintained as confidential by CAPER. All data reported by CAPER is aggregate data and is not linked to a particular individual.

Accreditation survey teams shall be granted access to Resident Files for the sole purpose of conducting an audit or review in connection with authorized institutional or program accreditation processes.

By completing this form for the Faculty of Medicine, Dalhousie University, I authorize the Faculty of Medicine to provide the required information to CAPER and to the other organizations described above.

I also agree to follow and be bound by the provisions of the Calendar and the regulations of the University, including any revisions, deletions, or additions made to them in the future. If admitted, I agree to pay all fees associated with my registration and enrollment at the University.

From time to time, you may be asked to participate in research studies regarding the content and delivery of medical education. You have the right to not participate in those studies.

I certify that the information I have provided is true to the best of my knowledge.

SIGNATURE: _____ DATE: _____

(Data Privacy: CAPER is committed to the principles of the Personal Information Protection and Electronic Documents Act. To review the CAPER Privacy Policy, contact the Director of CAPER (caper@afmc.ca).

THIS FORM MUST BE RETURNED TO THE DALHOUSIE UNIVERSITY POSTGRADUATE MEDICAL EDUCATION OFFICE (admissions.pgme@dal.ca) BY DATE INDICATED IN THE WELCOME EMAIL