



**COMMITTEE ON RURAL AND REGIONAL PRACTICE**

**RURAL & REGIONAL PHYSICIAN ENHANCEMENT  
TRAINING PROGRAM**

**APPLICATION FORM - RURAL & REGIONAL PHYSICIANS**

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**A. To be completed by the Applicant:**

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1. Name: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_  
\_\_\_\_\_
3. Phone Number: \_\_\_\_\_
4. Email address: \_\_\_\_\_
5. Gender: Male \_\_\_\_\_ Female \_\_\_\_\_
6. Please list the Saskatchewan communities in which you have practised and the start and end dates of your practice there:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Please list your qualifications including your licensure status in Saskatchewan and any specialty training you may have:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. In which area are you interested in obtaining enhanced training?  
\_\_\_\_\_  
\_\_\_\_\_
9. Where do you plan to obtain this training? \_\_\_\_\_
10. If this training is to be received at an institution other than the University of Saskatchewan, please explain the reasons.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. What is the length of the course? (minimum 6 months) \_\_\_\_\_
11. I have included my:  Curriculum Vitae       Letter from Program Director  
 Letter from institution indicating I meet the entrance requirements and describing the program

**B. To be completed by the Regional Health Authority:**

1. In which community will the applicant be practicing? \_\_\_\_\_
2. How many physicians are currently practicing in this community? \_\_\_\_\_
3. What is the practice structure of physicians in this community (solo/group)?  
\_\_\_\_\_
4. How will this community benefit from the specialized training the applicant plans to take?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Is the community currently equipped to provide additional services?  Yes  No  
If not, what additional resources, facility alterations or staffing would be required to permit the physician to provide the requested specialized services?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. What plans or initiatives has your region taken to ensure that the requisite supports are in place to support this physician?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Does the College of Physicians and Surgeons support the applicant's request to practice in your district?  Yes  No

**I declare that all information provided in this application is accurate and valid. I grant the Committee on Rural & Regional Practice permission to contact any individual referenced in this application.**

Signed:

_____ Applicant	_____ Regional CEO (or designate)	_____ RMA President (or designate)
	Printed: _____	Printed: _____
_____ Date	_____ Date	_____ Date

Please submit to: Committee on Rural & Regional Practice  
Saskatchewan Medical Association  
201 – 2174 Airport Drive  
Saskatoon, SK S7L 6M6