



Name \_\_\_\_\_  
Last First Middle initial

Street/PO box \_\_\_\_\_

City \_\_\_\_\_ Prov \_\_\_\_\_ PC \_\_\_\_\_

Email \_\_\_\_\_

1. Are you a resident of Saskatchewan? Yes  No

2. Have you ever lived in Saskatchewan? Yes  No

3. If you answered "Yes" to question 1 or 2, please indicate when:

From \_\_\_\_\_ to \_\_\_\_\_  
(year) (year)

4. Date of birth: \_\_\_\_\_  
(year) (month) (day)

5. Have you previously applied for a Saskatchewan Health/SMA bursary? Yes  No

6. Have you previously been awarded a Saskatchewan Health/SMA bursary? Yes  No

7. Do you plan to enter into any other financial arrangement with a return-in-service commitment?

Yes  No  If "Yes", please explain:

\_\_\_\_\_  
\_\_\_\_\_

8. Saskatchewan Health is committed to building opportunities for full participation by Aboriginal people in health-related occupations. Do you consider yourself to be Aboriginal (Indian, Metis or Inuit)?

Yes  No

**EDUCATION**

Type of institution	Name of institution	Name of degree	Date completed
University: Undergraduate			
Resident			
High school	Postal code:		

Current year in program \_\_\_\_\_ # of academic years remaining \_\_\_\_\_

Final completion date \_\_\_\_\_  
(month) (year)

Type of residency	Start date	Completion date

**REFERENCES** (other than family members)

**Career references** (people who have supervised you)

Name _____	Occupation _____
Street _____	
City/town _____	Postal code _____
Phone _____	Email _____
Name _____	Occupation _____
Street _____	
City/town _____	Postal code _____
Phone _____	Email _____

**Character references** (people who can attest to your character)

Name _____	Occupation _____
Street _____	
City/town _____	Postal code _____
Phone _____	Email _____
Name _____	Occupation _____
Street _____	
City/town _____	Postal code _____
Phone _____	Email _____

Information provided in your application will be kept confidential and will be used to determine eligibility for the Saskatchewan Health/Saskatchewan Medical Association Bursary. For those receiving a bursary, Saskatchewan Health officials may also use this information to maintain contact with you, until such time as your return-in-service commitment has been fulfilled.

I hereby certify that all information and statements made in this application are true and complete to the best of my knowledge and belief.	
_____	_____
Signature of applicant	Date

**Forward completed forms to:**  
Saskatchewan Medical Association  
201-2174 Airport Drive  
Saskatoon, SK S7L 6M6  
P: 306-244-2196  
F: 306-653-1631  
E: [SMA@sma.sk.ca](mailto:SMA@sma.sk.ca)  
Website: [www.sma.sk.ca](http://www.sma.sk.ca)