

COMMITTEE ON RURAL AND REGIONAL PRACTICE

FAMILY MEDICINE RESIDENT BURSARY APPLICATION

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 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 _____
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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 _____
<hr/>	
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
Website: www.sma.sk.ca

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SASKATCHEWAN
MEDICAL ASSOCIATION