RURAL & REGIONAL PRACTICE COMMITTEE

RURAL & REGIONAL PHYSICIAN ENHANCEMENT TRAINING PROGRAM

A. TO BE COMPLETED BY THE APPLICANT

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) _____

12. 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: Rural & Regional Practice Committee
Saskatchewan Medical Association
201 – 2174 Airport Drive
Saskatoon, SK S7L 6M6
By email: rsprograms@sma.sk.ca