The Royal College of Physicians and Surgeons of Canada

CLINICIAN INVESTIGATOR PROGRAM

Registration Form

Date: _____

Name of Resident: _____ **RCPSC ID#:** _____

Medical School Attended: _____ **Graduation Year:** _____

Resident Specialty/Subspecialty: _____

Department of Specialty/Subspecialty: _____

Current year of Training: PGY _____

Requested date of commencement for CIP research component: _____

Expected date of completion for CIP research component: _____

Current Source(s) of Funding: _____

Stream: ☐ Graduate (Masters) ☐ Graduate (PhD) ☐ Postdoctoral

Pathway: ☐ Continuous Training ☐ Fractionated Training ☐ Distributed Curriculum Training

Project Title: _____

Primary Location of Research: _____

Research Supervisor: _____

Department: _____

University: _____

Signature of Resident: _____

VERIFICATION OF STREAM

Graduate Stream: to be completed by the graduate school authority (Dean or delegate) **OR**
Postdoctoral Stream: to be completed by Associate Dean, Research, Max Rady College of Medicine

Name (please print): _____

Position: _____

Signature: _____

ENDORSEMENT OF CLINICAL PROGRAM DIRECTOR (IF APPLICABLE)

Name (please print): _____

Signature: _____

VERIFICATION OF REGISTRATION IN CIP

Signature of CIP Director: _____

FACULTY APPROVAL

Signature of Associate Dean, PGME: _____