# RHA Application for Medical Resident Bursary

**Regional Health Authority (RHA) requesting the medical resident bursary:** ***Please check only ONE.***

☐ Eastern Health ☐ Central Health ☐ Western Health ☐ Labrador-Grenfell Health

***The deadline for this application is January 31st of the academic year of application. Medical resident bursaries are only available in the last two years of residency training.***

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## *Part 1: To be completed by the Applicant*

### APPLICANT INFORMATION

Surname: _____ Given Name: _____ Initial: __

Previous Name (If applicable): _____

Social Insurance No.: __ __ __ __ __ __ __ __ __ Date of Birth: _ _/ _ _/ _ _ _ _ (DD/MM/YYYY)
(Canada Revenue Agency regulations require the submission of a social insurance number for taxation purposes.)

Current Mailing Address:
_____
_____
_____

Permanent Mailing Address (if different):
_____
_____
_____

Home Province: _____

Telephone Numbers: Home: (__ __ __) __ __ __ - __ __ __ __ Cell: (__ __ __) __ __ __ - __ __ __ __
Work: (__ __ __) __ __ __ - __ __ __ __ Pager: (__ __ __) __ __ __ - __ __ __ __

Email: _____

*Please provide an email address other than your school email address.*

Email (Personal):_____

### EDUCATION INFORMATION

Medical School Attended: _____ Date of Graduation: _ _/ _ _/ _ _ _ _
(DD/MM/YYYY)

Residency Program: _____

Location of Residency Program: _____Date of Completion*: _ _/ _ _/ _ _ _ _
(DD/MM/YYYY)
*May be anticipated completion date

## CONFIRMATION OF PREVIOUS FUNDING

Has the applicant previously received funding under this or any other program offered by the Department of Health and Community Services, i.e. Undergraduate Medical Student Bursary, Physician Signing Bonus etc.?
☐Yes ☐No

Has the applicant previously received a signing bonus or bursary offered by a RHA in Newfoundland and Labrador?
☐Yes ☐No

If the answer is yes to any of the above questions, please provide details and amounts: _____
_____

## *Part 2: To be completed by the RHA*

## COMMUNITY OF PRACTICE INFORMATION

Physician Type: Family Medicine ___
Specialist ___ Areas of Specialty or Sub-Specialty: _____

Name of Community/Facility of Full-Time Practice: _____

What services will be provided by the Applicant during the service agreement? (You may check more than one)

☐Day Clinics ☐ Emergency Department coverage ☐ Travelling Clinics ☐ Inpatient Services

Practice Start Date: _ _/ _ _/ _ _ _ _ (DD/MM/YYYY)

## SIGNATURES

**Please ensure that the following supporting documentation is attached:**
☐ *Letter of confirmation of the practice location from the RHA*
☐ *Letter of offer from a practice in the practice community or from the RHA outlining the full range of services appropriate to the specialty, and reflective of the needs of the RHA. Services may include, but are not limited to, emergency room coverage, day clinics, evening clinics, weekend clinics, obstetrics, institutions services and/or inpatient services* ***OR*** *letter of intent to hire/practice specifying that some combination of the services listed above will be required and determined prior to first day of practice.*

**Declaration by Applicant and RHA:**
*I certify that all information given on this application is complete and true to the best of my knowledge.*

*I authorize that the Government of Newfoundland and Labrador may collect information in this application and exchange that information as it considers necessary for the purposes of approving bursaries.*

*I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate repayment of current bursaries and disqualification from receiving future incentives. Collection, use or disclosure of personal information is in accordance with privacy legislation.*

Applicant Signature: _____ Date: _____

RHA Signature: _____ Date: _____

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***For office use only***

**Amount of Bursary Approved:**

| Recipient | One-Time Bursary Amount per Physician with a 36-Month Service Agreement | Community Level | Please check one: |
|---|---|---|---|
| Specialist | $90,000 | 0 | ☐ |
| | $70,000 | 1 | ☐ |
| | $60,000 | 2 | ☐ |
| | $50,000 | 3 | ☐ |
| Family Medicine | $90,000 | 0 | ☐ |
| | $70,000 | 1 | ☐ |
| | $60,000 | 2 | ☐ |
| | $50,000 | 3 | ☐ |
| | $25,000 | 3a | ☐ |

**Amount of Top-Up Approved:**

Was a top-up approved? ☐Yes ☐No If yes, indicate the amount of top-up approved: $_____

**Final Approval:**

Total Amount of Bursary Approved (Bursary + Top-up): $_____

Director of Physician Services Signature: _____ Date: _____