

Application to the Clinician Investigator Program (CIP)
Temerty Faculty of Medicine,
University of Toronto

Please fill out the entire application neatly and obtain ALL signatures, EXCEPT "Verification of Registration of CIP" and "Faculty Approval" on page 3.

Name: _____
 (Surname) (First name) Initial.

Current address: _____

Current Phone #: Home _____ Work _____
 Pager/Cell _____

U of T E-mail address: _____

UTORid: _____

U of T Student # (if applicable): _____

Permanent mailing address: _____

Permanent Phone #: Home _____ Work _____

**Deadlines January 10, 2022 for MOH-CIP Funding Competition and Applications
 (for July 1 Enrolment)
 May 1st, 2022 for Non-MOH-CIP Applications for July 1, 2022 Enrolment
 November 1st, 2022 for Non-MOH-CIP Applications for January 1st, 2023 Enrolment**

Email complete application to:
uoft.cip@utoronto.ca

Clinician Investigator Program
 Medical Sciences Building, Room 2256
 1 King's College Circle
 University of Toronto
 Toronto, ON Canada M5S 1A8
 Phone: (416) 978-7189
 Website: <http://www.cip.utoronto.ca>

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Please contact the CIP Office if you have any questions about your application

1. RESEARCH SUPERVISION

Signature of Research Supervisor: _____

Print Name: _____ Supervisor's E-mail: _____

Graduate Appointment(s) of Supervisor: _____

Address of Supervisor: _____

****All applicants, incl. non-thesis and/or non-traditional (non U of T) graduate program applicants, must submit a letter from their potential SGS-qualified supervisor attesting that he/she will be taking full responsibility for the trainee to receive a well-structured research experience for a minimum of two full years.**

2. CLINICAL DEPARTMENT & FUNDING

Please attach a letter of support from your Specialty/Subspecialty Program Director with whom you have discussed this application, verifying the following: (N.B. Program Director also SIGNS page 3)

- your status and year of training in your postgraduate medical education program
- endorsement of your registration in the Clinician Investigator Program, incl. guarantee of min. 80% protected research time, and departmental funding guarantee for min. 2 years (cc'd to Dept Chair & Business Officer)
- your research potential, interest, and ability to complete program

I have discussed this with my Program Director and understand the appointment & funding conditions specific to my program.
_____ initial by applicant.

N.B. CIP registrants may commence the research component of CIP training at any time agreeable to the **CIP Advisory Committee, the Program Director, and the participating Graduate Unit**. However, application to and acceptance into CIP must occur while applicant is registered in an accredited RCPSC-accredited resident program.

Expected completion date of **clinical training**: _____

I have applied to my clinical department for funding, e.g., Surgeon Scientist Program; Clinician Scientist Program (Medicine/Psychiatry) (specify program) _____

I have funding for a minimum of two years (granting agency, departmental, other)

Agency: _____

Amount: _____ Start Date: _____ End Date: _____

3. STREAM TO COMPLETION - There are two streams to completion of the CIP research component. **Please complete only one, section A OR B.**

• ALL APPLICANTS MUST SUBMIT A CURRENT CV, A 1-PAGE OUTLINE OF THEIR RESEARCH PROJECT, AND A LETTER OF INTENT (all requirements listed on the CIP website at www.cip.utoronto.ca)

A. Graduate Stream Applicants

CIP applicants who do not already hold a Ph.D. degree must spend a minimum of two years engaged in full-time study in a research program leading to a M.Sc. or Ph.D. degree.

I have applied to graduate unit(s) (specify) _____

I have been accepted into graduate unit _____ Proposed Start Date _____

I have already commenced graduate studies in (specify graduate unit) _____

B. Postdoctoral Stream Applicants

- start and end dates of your research project summary of previous research experience copies of publications (first page only)
- letter of reference from your previous research supervisor and/or Ph.D. supervisor
- letter confirming to follow standard procedures for monitoring of progress in CIP, and listing any courses to be completed (if required)
- List of two additional faculty members who, together with your supervisor, will serve as your research advisory committee and meet with you every six months to evaluate your research and progress

**ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA
CLINICIAN INVESTIGATOR PROGRAM REGISTRATION
INFORMATION**

Date: _____
 Name of Resident: _____ RCPSC ID #: _____
 Year & School of Medical Graduation: _____
 Specialty/subspecialty in which the research resident is enrolled: _____
 Current year of training: PGY _____
 Temerty Faculty of Medicine in which specialty residency is taking place: **University of Toronto**
 Expected date of commencement of full-time **research component** of CIP: _____
 Funding Source: _____

PROPOSED RESEARCH PROGRAM FORMAT

Please indicate which Stream:
 Postdoctoral Stream
 Graduate Stream Indicate Degree: M.Sc. *or* Ph.D. *or* Other (specify) _____
 Date _____ at **University of Toronto**

If M.Ed., are you registered with the Wilson Centre for Research Education? Yes No

Indicate Pathway: Continuous Training Distributive Curriculum Training Fractionated Training

Expected date of completion of CIP research component (mm/dd/yyyy): _____

Project Title: (please print): _____

Research Supervisor: _____

Department: _____ University: **University of Toronto**

Location of Research: _____

SIGNATURE OF RESIDENT: _____

Graduate School Endorsement

VERIFICATION of REGISTRATION or ACCEPTANCE in the **GRADUATE SCHOOL STREAM** by the **GRADUATE SCHOOL AUTHORITY** (director, graduate coordinator, or delegate) or verification of registration in **POSTDOCTORAL STREAM** by the **VICE DEAN, RESEARCH & HEALTH SCIENCE EDUCATION, TEMERTY FACULTY OF MEDICINE.**

Name (please print): _____

Position & Graduate Unit: _____

Signature: _____

<p>Endorsement of Concurrent Clinical/CIP Programs by Residency PROGRAM DIRECTOR: Name (please print): _____ Signature: _____</p>	<p>VERIFICATION OF REGISTRATION IN CIP: N. Jones, CIP Director Signature: _____</p>	<p>FACULTY APPROVAL M. Giuliani, Associate Dean, Postgraduate Medical Education Signature: _____</p>
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