

**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: \_\_\_\_\_  
 (Last Name, First Name)

Current address: \_\_\_\_\_  
 \_\_\_\_\_

Current Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_  
 Cell \_\_\_\_\_

U of T E-mail address: \_\_\_\_\_

UTORid: \_\_\_\_\_

U of T Student # (if applicable): \_\_\_\_\_

Permanent mailing address: \_\_\_\_\_  
 \_\_\_\_\_

Permanent Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_

**Email complete application to:**  
[uoft.cip@utoronto.ca](mailto: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>

The University of Toronto respects your privacy. The information on this form is collected pursuant to section 2(14) of the University of Toronto Act, 1971. It is collected for the purpose of administering admission, registration, academic programs, university-related student activities, activities of student societies, financial assistance and awards, graduation and university advancement, and for the purpose of statistical reporting to government agencies. At all times it will be protected in accordance with the *Freedom of Information and Protection of Privacy Act*. If you have questions, please refer to [www.utoronto.ca/privacy](http://www.utoronto.ca/privacy) or contact the University's Freedom of Information and Protection of Privacy Office at 416-946-5385, Room 201, McMurrich Bldg., 12 Queen's Park Crescent, Toronto, ON, M5S 1A1

*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 Accredited Residency 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: \_\_\_\_\_

**PLEASE NOTE:** The MOH-CIP Award covers the learner's salary and benefits under the PARO-OTH Agreement for one year of the minimum two-year program. MOH-CIP funded positions cannot be deferred to a future academic year. If your training status will be changing during the year or you are currently on leave, please reach out to [uoft.cip@utoronto.ca](mailto:uoft.cip@utoronto.ca) **prior** to applying.

**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 ONE-PAGE OUTLINE OF THEIR RESEARCH PROJECT, AND A LETTER OF INTENT (all requirements listed on the CIP website at [CIP Website - Prospective Trainees/Application Guide](#))**

**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:

Graduate Stream: Indicate Degree: M.Sc, Ph.D Postdoctoral  
DATE: \_\_\_\_\_ **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><b>Endorsement of Concurrent Clinical/CIP Programs by Residency</b> <b>PROGRAM DIRECTOR:</b> Name (please print):  Signature:</p>	<p><b>VERIFICATION OF REGISTRATION IN CIP:</b> <i>McCart, A, CIP Director</i>  Signature:</p>	<p><b>FACULTY APPROVAL</b> <i>Giuliani, M, Associate Dean, Postgraduate Medical Education</i>  Signature:</p>
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