

Canadian Glaucoma Society/Pfizer Canada
GLAUCOMA FELLOWSHIP Application

APPLICANT

Surname: _____ Given Name(s): _____

DEGREES HELD (Indicate the month & year attained, name of program and of University): _____

ACADEMIC APPOINTMENT or POSITION AT HEALTH FACILITY:

INSTITUTION: _____

FACULTY: _____

DEPARTMENT: _____

ADDRESS: _____

TELEPHONE: () _____ **E-MAIL:** _____

CITIZENSHIP: _____

SOCIAL INSURANCE #: _____

OUTLINE OF PROPOSED FELLOWSHIP (NAME OF INSTITUTION, DATES, ETC.)

(Attach additional sheet giving specific details)

Name of Supervisor

Address: _____

Telephone: (____) _____

Fax: (____) _____

E-mail: _____

FUTURE PROFESSIONAL PLANS

If you have applied for other financial assistance, please list sources and amounts.

ALL APPLICATIONS MUST BE ACCOMPANIED BY:

1. Applicants complete curriculum vitae including publication list
2. Letter of support from current Chairman of Department
3. Letter from Department verifying appointment following Fellowship or letter from Medical Director/ Health Department if returning to an area of need *if available*.
4. Letter of acceptance from Fellowship Supervisor where the Glaucoma Fellowship will be taken.

Signature of Applicant

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE, THE INFORMATION PROVIDED IN THIS APPLICATION AND ATTACHMENTS IS TRUE AND NO MATERIAL FACT HAS BEEN WITHHELD.

Signature of Applicant: _____

Date: _____

Additional Signatures Required:

We recommend the applicant acknowledge the commitment of the University to offer an academic position upon the completion of the fellowship *if available*.

SIGNATURE OF DEPT. HEAD _____ DATE: _____

Print Name: _____

SIGNATURE OF CHAIR: _____ DATE: _____

Print Name: _____

All applications are to be sent to:

Canadian Glaucoma Society/Pfizer Glaucoma Fellowship Committee Chair
Attention: Dr. Gordon Douglas
102-49 Richard Way SW; Calgary, Alberta; Canada T3E 7M8
Tel: 403-245-3730

Fax: 403-245-1058
Email: Seaview10@shaw.ca