

# AEROSPACE MEDICINE ELECTIVE

## Application for Aerospace Medicine Elective

Please ensure all relevant information is included in the application form. Any supplementary documents (e.g. Curriculum vitae) will not be evaluated. **Except for aerospace medicine related activities, training or associations, only include experience, service, activities and awards performed or received after high school.**

### Privacy Notice

Necessary measures have been taken to protect the confidentiality of the information you provide. The information you provide is collected under the authority of the CSA Act. This information will be used for the selection of candidates for the Aerospace Medicine Elective. Personal information of candidates not retained will be stored in the Personal Information Bank CSA PPU 030 for 2 years and then destroyed. Personal information (such as contact information, biographical information, etc) about the successful candidates will be retained along with their research reports for historical purposes. It is protected under the Privacy Act. According to the Privacy Act, you have rights with respect to the information you submit. You may, upon request,

- be given access to your file
- have incorrect information corrected or have a notation attached.

For more information about your rights see [InfoSource](#).

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## Application for Aerospace Medicine Elective

Please type or print clearly in black ink only.

<b>ELECTIVE APPLYING FOR (Preferences will assist the selection committee in assigning successful candidates to the most suitable program)</b>				
<input type="checkbox"/> JSC Aerospace Medicine Clerkship (October 2010)	<input type="checkbox"/> KSC Medical Elective (October 2010)			
<input type="checkbox"/> JSC Aerospace Medicine Clerkship (April 2011)	<input type="checkbox"/> UTMB Introduction to Aerospace Medicine (July 2011)			
<input type="checkbox"/> JSC Aerospace Medicine Clerkship (October 2011)	<input type="checkbox"/> No preference			
Reason for Elective Preference:				
<b>APPLICANT INFORMATION</b>				
Family Name:	Given Name:	Initials:		
Current Mailing Address (all correspondence will be mailed to this address):		Telephone:		
		Fax:		
		Email:		
<b>CITIZENSHIP</b>				
<input type="checkbox"/> Canadian citizen	<input type="checkbox"/> Permanent Resident of Canada	<input type="checkbox"/> Other		
Indicate country of citizenship:				
<b>ACADEMIC BACKGROUND</b>				
Degree	Name of Discipline	Department, institution and country	Start date (yyyy/mm)	Graduation date (yyyy/mm)
Bachelor				
Master				
M.D.				
Residency				
Doctorate				

PROTECTED WHEN COMPLETE



Name:

**WORK EXPERIENCE (Any work experience, not limited to medical experience)**

Position held and nature of work (begin with most recent)	Organization and department	Period (yyyy/mm-yyyy/mm)

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Name:

<b>RESEARCH EXPERIENCE</b>		
Position held and nature of work (begin with most recent)	Organization and department	Period (yyyy/mm-yyyy/mm)

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Name:

**PUBLICATIONS AND PRESENTATIONS (begin with most recent)**

Empty box for listing publications and presentations.

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Name:

<b>COMMUNITY SERVICE</b>		
Position held and nature of work (begin with most recent)	Organization and department	Period (yyyy/mm-yyyy/mm)

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Name:

**AEROSPACE MEDICINE RELATED ACTIVITIES, TRAINING OR ASSOCIATIONS** (include activities related to aviation, space or expeditionary medicine (e.g. pilot, International Space University, wilderness & remote medicine, MEDEVAC)). May include activities during high school.

Activity, training or membership in association (begin with most recent)	Organization and department	Period (yyyy/mm-yyyy/mm)

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Name:

**OTHER ACTIVITIES (e.g. competitive sports, diving, military service, leadership roles)**

Nature of activity (begin with most recent)	Period (yyyy/mm-yyyy/mm)
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Name:

<b>AWARDS</b>	
Nature of award (begin with most recent)	Date received (yyyy)

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Name:

**PERSONAL STATEMENT**

Please state the reasons you wish to participate in this elective and how this elective relates to your future goals and career plans.

Please state how you hope to contribute to aerospace medicine in Canada.

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Name: \_\_\_\_\_

**Have you or will you request or receive financial assistance from other funding sources, including other federal, provincial/territorial or municipal departments, to participate in this program?**

<input type="checkbox"/> Yes  Indicate source and level of assistance:	<input type="checkbox"/> No
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**Have you previously received grant or contribution funding from the Canadian Space Agency?**

<input type="checkbox"/> Yes  Indicate name of program:	<input type="checkbox"/> No
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**Are you a former public servant who falls under the Conflict of Interest and Post-Employment Code for Public Office Holders or the Values and Ethics Code for the Public Service?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**LANGUAGE OF CORRESPONDANCE**

<input type="checkbox"/> English	<input type="checkbox"/> French
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**SIGNATURE**

I certify that the information given in this application package is complete and accurate, and I understand that to make false or fraudulent statements within this application may result in denial of admission. Should any of the information I have given change prior to my entry into the program, I shall immediately notify the Canadian Space Agency.

APPLICANT'S SIGNATURE:

DATE:

Please indicate how you heard about this program: