

SCHOLARSHIP APPLICATION
 Physician Leadership and
 Quality Improvement Training Program



APPLICANT INFORMATION – Physician to complete

Physician Name: _____ MSP #: _____
 Title: _____ Specialty: _____ GP SP
 Email: _____ Telephone #: _____
 Mailing Address: _____
 City: _____ Postal Code: _____
 Physician Signature: _____ Date: _____

TRAINING REQUEST INFORMATION – Physician to complete

Date(s) of Training and City: _____
 Organizer: _____
 Training Event Title: _____
 Intended Outcome of Training: _____
 Are you hoping to apply learnings to your current or future role? Current Role: _____
 Future Role: _____

FUNDING INFORMATION – Physician to complete

Criteria for Funding: Tuition and travel expenses up to a maximum of \$10,000 per physician. Funding will cover actual tuition fees and travel costs (receipts are required). Time/compensation for attendance is excluded from funding.
 Tuition Fees: _____ Estimated Travel Costs: _____

HEALTH AUTHORITY ENDORSEMENT
Physician to seek endorsement before submitting for approval to the JCC

Vice President,
 Medicine Name: (Print) _____
 Comments: _____
 Health Authority: _____ VCH _____ FHA _____ VIHA _____ PHSA _____ IHA _____ NHA _____ FNHA
 VP, Medicine Signature _____ Date: _____

Please send completed applications to:
 Wendy Lo, Regional Leader
 Physician Relations & Compensation
 (E) wendy.lo@vch.ca
 (P) 604-875-4864 (F) 604-875-4593