



C EDUCATIONAL INFORMATION

Full name of your educational institution for 2006/2007: _____

Student Number: _____

If you will be attending **outside** the Province of Manitoba provide the mailing address of that institution:

Check (✓) the program of study you are applying for this grant as:

an Undergraduate: Year 3* _____ or Year 4 _____

OR a Post Graduate/Resident PGY # _____ of # _____

OR a Resident in a Sub-Specialty Program PGY # _____ of # _____

* *If you are in Year 3 of an undergraduate medical program at the University of Manitoba or University of Ottawa (in French), Faculty of Medicine, you are also required to provide a separate signed letter, together with this Application, expressing your commitment to return service in a rural community in the Province of Manitoba (excluding Winnipeg and Brandon). Applicants are required to provide letters of support from a rural community. For further details refer to the MSREAP brochure at www.gov.mb.ca/health/msrfap.*

1. If you are an **undergraduate** or **postgraduate resident**, indicate the start and end dates of this year's program (e.g., 06/07/01 to 07/06/30):

Start: 2006 _____ End: 2007 _____
yy / mm / dd yy / mm / dd

Postgraduate/residency program (include planned): _____
(RCPSC/CFPC program name)

Expected date of completion of your postgraduate/residency program: _____
yy / mm / dd

Are you planning to enroll in a sub-specialty training program? Yes No Unknown

If known, name your sub-specialty program: _____

Expected date of completion of this training: _____
yy / mm / dd

2. If you are enrolling this year in a **sub-specialty training program**, indicate the start and end date of this year's program (e.g., 06/07/01 to 07/06/30):

Start: 2006 _____ End: 2007 _____
yy / mm / dd yy / mm / dd

Name of the sub-specialty training program: _____

Expected date of completion of sub-specialty training: _____
yy / mm / dd

3. If you are in a postgraduate/residency/sub-specialty program **outside** the Province of Manitoba, you must provide, together with this Application, **verification** of your graduation from The University of Manitoba, Faculty of Medicine, or the Francophone Medical Program at the University of Ottawa, in the form of the degree that was issued to you by the university. (*NOTE: A legible photocopy of your degree will suffice.*) You must also provide letters confirming **proof of your enrollment and proof of attendance at a later date** in the postgraduate/residency/sub-specialty program and provide the following contact information:

Name: _____ Title: _____
e.g. Departmental Head or Residency Program Head

E-mail Address: _____ Fax Number: (____) _____

Phone Number: (____) _____



D FINANCIAL INFORMATION

Have you entered into any signed or oral contract(s) or commitment(s) with the Government of Manitoba including MSRFAP, any other provincial or territorial government, the Government of Canada, any local or municipal government, or any other organization or funder **under which you have agreed or committed to return service?**

Yes

No (you must check (✓) one)

If you checked Yes, please describe and provide detailed information regarding such contract(s):

(attach a separate sheet if more space is required)

If it is determined that you qualify for financial assistance under the MSRFAP, the funds comprising such financial assistance will be electronically transferred by Manitoba Advanced Education and Training to your personal account once your contract is signed. Either provide a void cheque for this account or the name of your financial institution, address, transit number and account number.

Financial Institution: _____ Address: _____

City/Province: _____ Postal Code: _____

Transit Number: _____ Account Number: _____

E ALTERNATE CONTACT - *Please provide 2 contacts*

Name of alternate contact: _____

Relationship: _____ Address: _____

Phone Number: (____) _____ City/Province: _____ Postal Code: _____

Name of second alternate contact: _____

Relationship: _____ Address: _____

Phone Number: (____) _____ City/Province: _____ Postal Code: _____

NOTE: An alternate contact may be used to assist us in contacting you.

F REPRESENTATION/ACKNOWLEDGMENT/AUTHORIZATION/DECLARATION

I hereby represent that:

- All information provided on and/or with this application is complete, accurate and true in every respect.
- I will not and have not received financial assistance from any other province, government, country, or funder in return for which I agree to provide a return of service other than reported in Section D.

I hereby acknowledge that:

- All personal information provided on this Application for the MSRFAP is being collected by Manitoba Advanced Education and Training, Student Aid Branch under the authority of the MSRFAP and *The Student Aid Act* and the applicable Regulations thereunder, and will be used to determine whether I qualify for the purpose of receiving any financial assistance under the MSRFAP and to administer any financial assistance that I may be approved to receive under the MSRFAP. Such personal information is protected by Protection of Privacy provisions of *The Freedom of Information and Protection of Privacy Act (Manitoba)*. If I have any questions regarding the collection of personal information, I can contact Manitoba Advanced Education and Training, 401 - 1181 Portage Avenue, Winnipeg, Manitoba R3G 0T3 at (204) 945-8509.

(over)



F REPRESENTATION/ACKNOWLEDGMENT/AUTHORIZATION/DECLARATION *continued*

- It is my responsibility to immediately notify Manitoba Student Aid, in writing, of any changes to personal, educational, financial or alternate contact information that I have provided on this Application.
- If I fail to provide complete, accurate and updated information this may result in my being required to repay all of the financial assistance that I receive under the MSRFAP, and may preclude me from receiving any future financial assistance under the MSRFAP.
- If this Application is approved, I will sign a **Contract** with the Province of Manitoba in the form and content approved for this purpose by Manitoba Health.

I hereby authorize:

- Manitoba Student Aid to receive information (including education and employment) from and to provide information to educational institutions, financial institutions, employers, service providers, government agencies or authorities and any other persons considered necessary for the purposes of verifying or investigating this Application; administering and enforcing the contract and any laws pertaining to student aid; and keeping and analyzing statistical records. Also, I consent to Manitoba Health disclosing my name, mailing address, year of graduation/postgraduation, etc. for recruitment purposes to prospective employers in the Province of Manitoba, including (but not limited to) regional health authorities, hospitals and clinics.

I make this Declaration and Authorization knowing that:

- In return for any financial assistance received in the 2006/2007 year (July 1/06 - June 30/07), upon completion of my postgraduate medical training program, I will return to/remain in the Province of Manitoba and practice in the medical field for which I was trained, for a minimum period equal to one year (12 months full time). Should I fail to fulfill the full 12 months return of service, I will immediately repay the balance owing under the **Contract**, plus interest accrued from the day the financial assistance was provided to the financial institution referred to in Section D of this Application.
- Financial assistance under this program is taxable to the recipient in the year in which it is received. While there will be no deductions at source, a T4 will be issued and I am responsible for including the amount of the financial assistance in my income in the year in which it is received.
- If, for any reason, I do not complete my undergraduate medical training or postgraduate/residency/sub-specialty program, as the case may be, I will be required to immediately repay all of the financial assistance that I receive under the MSRFAP, plus interest accrued from the day it was provided to my financial institution.
- If I default in returning service, fail to repay any financial assistance received under the MSRFAP or provide any inaccurate, false or misleading information on this Application, notice of such default may be provided to Canada Revenue Agency, financial institutions, service providers, or collection agencies acting on behalf of the Government of Manitoba, and my credit rating will be affected. If I default on my MSRFAP debt repayments, Section 47 of *The Financial Administration Act* (right of set-off) may apply.
- I may be required to immediately repay all or part of the assistance I receive if my assessment is found to be inaccurate, even if such inaccuracy is a result of an inadvertent error on my part or on the part of the Department of Advanced Education and Training.
- There is no obligation on the part of the Government of Manitoba to provide me with financial assistance under the MSRFAP.
- I have read and fully understand the contents of this Application.

Signature _____ Date _____

Should you wish to provide any additional information that you feel may assist Manitoba Health and Manitoba Advanced Education and Training in reviewing your Application, please do so on a separate dated and signed sheet.