Saskatchewan Health Authority

Application for Saskatchewan Health Authority

High-Demand Resident Incentive

Personal Information

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Street Address: _____

City/Town: _____ Postal Code: _____ Email: _____

Phone #: _____

What residency program are you in?

- ☐ Anesthesiology
- ☐ Diagnostic Radiology
- ☐ Emergency Medicine

What year are you in?

- ☐ PGY4
- ☐ PGY5

Are you planning to take additional training beyond the specialty program that you are currently enrolled in, or will you be on any leaves during the remainder of your residency program? Please elaborate:

_____

_____

_____

Incentive and Medical Practice Information

1. Please describe your medical practice plans following completion of residency if known (including communities, anticipated dates started, etc.)

   _____

   _____

   _____

2. Have you previously received funding for the High-Demand Resident Bursary?
   - ☐ Yes
   - ☐ No

Education

Undergraduate Medical Degree

University of undergraduate medical degree:_____

Program completed:_____ Date of completion: _____

Residency

- ☐ I am currently enrolled as a resident at the University of Saskatchewan
- ☐ My expected date of completion of residency is:_____

Recruitment Consent (Required)

- ☐ I consent to be contacted by the SHA and/or other healthcare agencies, including the Saskatchewan Healthcare Recruitment Agency (SHRA), for the purposes of recruitment.

Return of Service

Upon completion of the specialty resident program, physicians are required to provide service for a specified period (one year per year of funding) in an eligible community in Saskatchewan.

Information provided in your application will be used to determine eligibility for the High-Demand Resident Incentive and may be shared with affiliate healthcare organizations for the purposes of recruitment and return of service tracking.

Signature

For those receiving an incentive, the Saskatchewan Health Authority and/or Ministry of Health officials may also use this information to maintain contact with you, until such time as your return of service commitment has been fulfilled.

I hereby certify that all information and statements made in this application are true and complete to the best of my knowledge and belief.

Signature of Applicant: _____ Date: _____

Email completed form to physicianincentives@saskhealthauthority.ca