MEMORIAL UNIVERSITY

Faculty of Medicine

Program Transfer

AUTHORIZATION OF RELEASE

I acknowledge, that in addition to the documents submitted with this transfer request, the Postgraduate Medical Education office will share to the

_____ residency training program, the following documentation:

- In-Training Evaluations/Assessment portfolio (CBD/Triple-C);
- CaRMS application, if requested;
- Summary of Residency Training record – including extended leaves from the program;
- Summaries of ongoing investigations and appeals; and,
- Current or previous remediation programs.

Name (Please Print):

Signature:

_____ _____

Date (mm/dd/yy)

_____

The personal information requested on this form is collected under the general authority of the Memorial University Act (RSNL1990 CHAPTER M-7) for the purpose of assessing the request for Transfer and to form part of your student record and be used to document your progress in your Program. Questions concerning the collection, use, and disclosure of this information should be directed to the Information Access and Privacy Office