**SECTION B. GROUP APPLICATION**

1. **ADMINISTRATIVE INFORMATION**

**PHYSICIAN LEAD**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: Ontario Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (preferred): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email 2nd: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_ Business Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_\_ Cell: (\_\_\_\_\_)-\_\_\_\_-\_\_\_\_\_\_

Years in Practice: \_\_\_\_\_\_\_\_\_ Present Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: Ontario Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_)-\_\_\_\_-\_\_\_\_\_ ext.\_\_\_\_\_\_ Fax: (\_\_\_)-\_\_\_\_-\_\_\_\_\_\_ Website:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INDIVIDUAL**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: Ontario Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (preferred): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email 2nd: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_ Business Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_\_ Cell: (\_\_\_\_\_)-\_\_\_\_-\_\_\_\_\_\_

1. **PROPOSED LEADERSHIP ACTIVITY**

Please describe the leadership activity according to the following sections.

| **Description of Activity** |
| --- |
|  |

| **Purpose and/or Benefit of the Proposed Activity** |
| --- |
|  |

1. **PROGRAM ACCREDITATION**

Please list what organization has accredited the proposed activity.

1. **PARTICIPANTS**

Describe the proposed number of applicants including their background. It is expected that all anesthesiology-related individuals are active (dues-paying) members of Ontario’s Anesthesiologists.

Number of Participants: \_\_\_\_\_\_\_

| **Description of Participants** |
| --- |
|  |

1. **PROGRAM SUPPORT**

Please describe any support the initiative has already secured for the activity. The program recognizes the need for multiple sources and special emphasis will be granted to activities that have secured outside and potentially matching sources of support. A separate page may be attached to the questionnaire including letters describing other sources of support.

1. **PROPOSED BUDGET**

Please provide a total budget for the initiative including a rough breakdown. A separate page may be attached to the questionnaire including more detail.

1. **Reimbursement:**

Successful applications will receive 50% of the award upon selection and the remaining 50% of the award upon receiving a Summation Report describing the event/course including what was learned, how it will impact participant(s) present or future leadership roles, and related comments. The Summation Report must be submitted within 60 days of completion of the event to be eligible for the remaining 50% support. Failure to submit a report in this timeframe will result in forfeiture of the remaining amount of the award.

1. **ATTESTMENT AND RECOMMENDATION (must be completed for consideration)**

**I certify that my responses are true and factual. I also agree to provide a report within 60 days of the scheduled completion of the activity.**

Physician Lead (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician Lead: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit your completed form and supporting documents to** [info@ontariosanesthesiologists.ca](mailto:info@ontariosanesthesiologists.ca)