



Premier's Summit Award in Medical Research

Appendix B: Applicant Information Form

Family Name	Given Name Initial(s)	Middle
Title Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Prof. <input type="checkbox"/>		

Addresses

Primary Affiliation Name	Primary Affiliation Address
Start Date:	
Courier Address (if different from mailing address)	Temporary Address (if applicable)
	Start Date: End Date:
Email	Web page

Contact Numbers

Primary Phone	Primary Fax
Secondary	
Temporary	Temporary
Start Date: End Date:	Start Date: End Date:

Citizenship Canadian <input type="checkbox"/> Other <input type="checkbox"/> Other Country of Citizenship:	Permanent Residence in Canada Permanent Resident <input type="checkbox"/> Date of Permanent Residency status Have you applied for permanent residency? Yes <input type="checkbox"/> No <input type="checkbox"/>
Correspondence language	English <input type="checkbox"/> French <input type="checkbox"/>
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth

Signatures:

Each of the undersigned:

- Confirms they have read the Premier's Summit Award in Medical Research Guidelines and certifies that the information contained in the nomination is truthful, complete and accurate and fully complies with the Premier's Summit Award program eligibility criteria.
- Consents to the sharing of information provided in this application with the Award

