



**Medical Education Services**

**RESIDENT INFORMATION**

**LEGAL NAME:** \_\_\_\_\_  
First, Middle, Last (specify N/A if no middle name)

**CONTACT INFORMATION:**

**STREET:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **PROVINCE:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_

**HOME PHONE#:** \_\_\_\_\_ **CELL PHONE #:** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_

**EMERGENCY PHONE:** \_\_\_\_\_

**RELATIONSHIP of CONTACT** \_\_\_\_\_

**PERSONAL INFORMATION (mandatory for employment):**

**GENDER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**SIN#:** \_\_\_\_\_

*Please be aware that any personal information you share with Nova Scotia Health Authority on this form may be shared, as required, to administer your residency with other organizations such as Maritime Resident Doctors, CMPA, Funding agencies, Dalhousie University, and other organizations. Your signature on this form will constitute consent to share information with the legitimate parties as above.*

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY:**

**TOS:** \_\_\_\_\_

**PGY LEVEL:** \_\_\_\_\_

**SOS:** \_\_\_\_\_

**PROGRAM:** \_\_\_\_\_

**Position #:** \_\_\_\_\_