



BURSARY APPLICATION FORM FAMILY PHYSICIAN (MEDICAL STUDENT BURSARY)

1. PERSONAL DATA			GENERAL INFORMATION	
Surname	First Name	Middle	Are you a current employee of Sun Country Health Region? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Address Street/Box			Have you previously applied for a Sun Country Health Region Bursary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
City/Town		Postal Code	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home phone		Other	Have you previously been awarded a Sun Country Health Region Bursary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E-mail				
Social Insurance Number (SIN#):				
Sun Country Health Region is committed to building opportunities for full participation by Aboriginal people in health-related occupations. Responding to the question below is strictly voluntary. Do you consider yourself to be Aboriginal? <input type="checkbox"/> Yes <input type="checkbox"/> No				
2. EDUCATIONAL PROGRAM (for which you are requesting bursary assistance)				
Program Name	Educational Institute/Facility Delivering Program	Program Start Date	Final Completion Date	
	**Please attach confirmation of enrollment in the program – NOTE receipts of tuition fees are not acceptable proof of enrollment.			
Please specify what your expected professional designation will be upon successful completion of program:				
3. RETURN IN SERVICE				
Bursary recipients are required to sign a formal agreement to work in Sun Country Health Region. Please indicate if you have a preference to work in a specific location or area of the Region. Placements will be determined by vacancies in the Health Region				
I agree to let Sun Country Health Region use my name and photo for publicity purposes. <input type="checkbox"/> Yes <input type="checkbox"/> No				
I hereby certify that all statements made in this application are true and complete to the best of my knowledge and belief.			Mail Completed Form To:	
			Human Resource Department Sun Country Health Region PO Box 2003 Weyburn SK S4H 2Z9 Tel: (306) 842-8320 Fax: (306) 842-8740	
Signature of Applicant _____			Date _____	

- Bursaries are considered taxable income
- All bursaries will be issued in Canadian funds

SUN COUNTRY HEALTH REGION MEDICAL STUDENT BURSARY

As a recipient of funding provided through the Sun Country Health Region Bursary Program I agree to a return of service with the Sun Country Health Region for a period of up to four years.

Students enrolled in 3 – 4 or 1 – 2 years residence program related to Family Medicine are eligible for up to \$25,000.00 per student year, with a maximum \$100,000.00 over 4 years of studies with a maximum 4 years return of service (full time equivalent). Please complete the following:

- 1st time applicant - \$25,000 = 1 year return of service
- 2nd year - \$25,000 - \$50,000 = 2 years return of service
- 3rd year - \$25,000 - \$75,000 = maximum 3 years return of service
- 4th year - \$25,000 - \$100,000 = maximum 4 years return of service

If the recipient of funding does not employ with Sun Country Health Region or leaves the employ of Sun Country Health Region before the end of their service commitment, the bursary must be repaid in full at a pro-rated level based on the length of service time remaining.

Please Note: Due to the demographics of Sun Country Health Region, this bursary is intended for students who plan to work in the area of Family Medicine with a General Practitioner designation.

In consideration of the sum of \$_____ paid to me by the Sun Country Health Region I agree to work for the Sun Country Health Region for the period of _____ year(s). The term of this agreement would commence on the date that the course is completed. I agree to be available for a full time practice for the term of this contract. In the event I terminate my contract prior to fulfilling my commitment, I agree to repay the forgoing amount on a pro-rated basis.

Applicant's Signature

Date