***Profile Form***

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| DeptSigPsychiatry240908FINAL655-150dpi | DEPARTMENTAL CONTACT INFORMATION:**Department of Psychiatry****250 College Street, Suite 832** **Toronto, ON, CANADA M5T 1R8** |

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| [ ]  **MR** [ ]  **MS**[ ]  **DR** [ ]  **MISS**[ ]  **PROF** [ ]  **MRS** | **SURNAME** | **FIRST NAME** | **INITIALS** |
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| **PERSONNEL NUMBER** | **SOCIAL INSURANCE NUMBER** | **SEX** | **BIRTHDATE****DD/MM/YYYY** |
| To be given |  | [ ]  **M** [ ]  **F** [ ]  **Another** |  |

|  |  |
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| **CITIZENSHIP** | **VISA STATUS** |
| [ ]  CANADIAN [ ]  U. K.[ ]  AMERICAN [ ]  OTHER:       | [ ]  CANADIAN CITIZEN[ ]  EMPLOYMENT AUTHORIZATION[ ]  LANDED IMMIGRANT |

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|  | **OFFICE ADDRESS (do NOT leave blank)** | **HOME ADDRESS** |
| **INSTITUTION NAME**(Private Practice, if none) |       |       |
| **STREET ADDRESS**  |       |       |
| **Unit, Building, Dept, etc.** |       |       |
| **CITY, PROVINCE** |       |       |
| **POSTAL CODE** |       |       |
| **COUNTRY** (If not Canada) |       |       |
| **TELEPHONE** |       |       |
| **FAX** |       |       |
| **EMAIL** |       |       |
| **DIVISIONS** Check the **LEFT** box to indicate your **primary** program/division(s).Check the **RIGHT** box to indicate your **second** program/division (if applicable) | [ ]  [ ]  Child & Youth Mental Health Division[ ]  [ ]  Forensic Psychiatry Division[ ]  [ ]  Geriatric Psychiatry Division[ ]  [ ]  Consultation/Liaison Psychiatry Division[ ]  [ ]  Adult Psychiatry and Health Systems Division *(General Psychiatry; Health Systems)* | [ ]  [ ]  The Psychotherapies, Humanities and Education Scholarship Division *(RISE; the Psychotherapies; Health Arts & Humanities)*[ ]  [ ]  Equity, Gender and Population Division *(Culture, Community and Health Studies; Women’s Mental Health, TAAPP)*[ ]  [ ]  Brain and Therapeutics Division (Addictions; Mood & Anxiety; Neurosciences; Schizophrenia)  |
| **RANK** | [ ]  Lecturer[ ]  Assistant Professor | [ ]  Associate Professor[ ]  Full Professor |
| **APPOINTMENT TYPE** | [ ]  Full-Time[ ]  Part-Time | [ ]  Adjunct[ ]  Status Only (for academic appointments/non-clinician) |
| **POSITION DESCRIPTION****(MD FACULTY ONLY)** | [ ]  Clinician Teacher[ ]  Clinician Educator[ ]  Clinician Quality Improvement | [ ]  Clinician Investigator[ ]  Clinician Scientist[ ]  Clinician Administrator |
| **CROSS APPOINTMENT** | Home Department (if not Dept of Psychiatry): |  |
| **APPOINTMENT DATE** | START DATE is indicated within your offer letter  |  |

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| **EDUCATION-DEGREES, FELLOWSHIPS** | **INSTITUTE- NAME, CITY, COUNTRY** | **YEAR OBTAINED** |
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| **Licensure Data (if applicable)** | **CPSO #:**  |

I hereby certify that the above information is correct.

**Date:** **Signature:**