***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:**