MEDICAL COUNCIL OF CANADA
LE CONSEIL MÉDICAL DU CANADA

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PRE-DIPLOMA TRAINING ATTESTATION FORM

THIS FORM IS TO BE COMPLETED FOR INTERNATIONAL MEDICAL GRADUATE APPLICANTS for whom a year or more of pre-diploma postgraduate clinical medical training (e.g., compulsory rotating internship) is required to be completed **BEFORE** the medical degree diploma is awarded. This training would occur **AFTER** the academic requirements and clerkship training have been completed. The pre-diploma training must be comparable to a first-year postgraduate residency training program in Canada where the trainee has the direct responsibility for patient care and treatment above and beyond that assigned to a clinical clerk.

Please complete the clinical clerkship and pre-diploma postgraduate clinical medical training section below to facilitate the review. The original of this completed form must be submitted (a photocopy will not be accepted) along with a copy of the **full medical school transcript** and translation if applicable.

PLEASE PRINT CLEARLY or TYPE

THIS IS TO CERTIFY THAT

_____ _____
Graduate's given name(s) Surname

has completed all requirements for the medical degree on: _____ (*yyyy/mm/dd*). His/her final medical diploma was issued on _____ (*yyyy/mm/dd*), after a compulsory period of postgraduate training (PGT). This training was completed from _____ (*yyyy/mm/dd*) to _____ (*yyyy/mm/dd*).

Details of clinical clerkship training:

Hospital/Teaching institution	City/Country	from year/month/day	to year/month/day	Program/Discipline

Both pages of this form MUST be **SIGNED** and **SEALED**. Also, any supporting documentation that provides a more in-depth description of the training program and/or a curriculum outline for the degree and diploma may be useful.

Certified by: _____ _____
Signature of **Dean** or Person responsible for the PGT Program — Name (print)

Title: _____ _____
Name of Medical School or Institution

City/Country: _____

Date: *year* _____ *month* _____ *day* _____

_____
University seal or stamp

PLEASE PRINT CLEARLY or TYPE

Graduate's given name(s) _____ Surname _____

Details of pre-diploma postgraduate clinical medical training:

Hospital/Teaching institution	City/Country	from year/month/day	to year/month/day	Program/Discipline
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	
		from	*to*	

Both pages of this form MUST be **SIGNED** and **SEALED**. Also, any supporting documentation that provides a more in-depth description of the training program and/or a curriculum outline for the degree and diploma may be useful.

Certified by: _____ _____
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Title: _____ _____
Name of Medical School or Institution

City/Country: _____

Date: *year* _____ *month* _____ *day* _____

_____
University seal or stamp