Faculty of Medicine

Postgraduate Medical Education
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CONSENT TO DISCLOSE

APPLICATION FOR RESIDENCY TRAINING AT MEMORIAL UNIVERSITY

I, _____, hereby authorize the Canadian Resident Matching Service (CaRMS) and the College of Physicians and Surgeons of Newfoundland and Labrador (College), to disclose a complete copy of my Memorial University CaRMS application and College file pertaining to my Application for Educational Registration, including all documents submitted by me and all documents obtained by the College as part of the review of my Application, with the office of Postgraduate Medical Education at Memorial University.

This consent form is valid for a period of one year from the date of application to CaRMS.

_____
Applicant's Name (Please Print)

_____
Applicant's Signature

_____
Date