

## Clinic Seeking Locum

**Questionnaire** (Please print legibly or type into this form)

**Logistics**

Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Clinic Hours: \_\_\_\_\_

**Dates Locum Required:** \_\_\_\_\_

Comments: \_\_\_\_\_

**Practice Operations**

Does this clinic have a walk-in component? Yes                  No

**Daily Practice**

Do you use EMR? Which one? Yes                  No

**Physician Preference/Practice Style**

Language any special requirements? Yes                  No

**Patient Panel**

How many patients will the locum see per/day? \_\_\_\_\_

Clinic contact person: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Fax or email this form to Sue Cavanagh: FAX: 403.284.9518 Email: sue.cavanagh@cfpcn.ca**