

<b>Questionnaire</b> (Please print legibly or type into this form)					
<b>Logistics</b>					
Clinic Name: _____					
Clinic Address: _____					
Clinic Hours: _____					
<b>Practice Operations</b>					
Are you looking for a full or part-time physician?				F/T	P/T
Do you have a walk-ins?				Yes	No
<b>Services</b>					
Do you offer any special services at your clinic? If yes, what ones?				Yes	No
Are medical procedures performed in your clinic?				Yes	No
<b>Daily Practice</b>					
What are your clinic appointment times? _____					
Do you use an EMR? If so, which one? _____				Yes	No
<b>Physician Preference/Practice Style</b>					
Any special language requirements? (please state if so) _____					
Are there areas of special interest in your clinic? (such as sports med, geriatrics, obstetrics) _____					
<b>The team</b>					
What type of staff and allied health professionals do you have in your clinic?					
MOA	Yes	No	HMN	Yes	No
Receptionist	Yes	No	Dietitian	Yes	No
RN/LPN	Yes	No	Respiratory Educator	Yes	No
BHC	Yes	No	Other: (please state)		
<b>Vacation</b>					
Do you have locum coverage or does the physician find his/her own locum?					
Other (comments): _____					
<b>Patient Panel</b>					
Would you like the physician to take on new patients?				Yes	No
Would you like the physician to come to your clinic with a full panel?				Yes	No
Clinic contact person for physician to contact: _____					
Phone: _____			Email: _____		
<b>Fax or email this form to Sue Cavanagh: FAX: 403.284.9518 Email: <a href="mailto:sue.cavanagh@cfpcn.ca">sue.cavanagh@cfpcn.ca</a></b>					

