

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 | | |