

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		