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| Questionnaire (Please print legibly or type into this form) | | | | | |
| Logistics | | | | | |
| Clinic Name: | | | | | |
| Clinic Address: | | | | | |
| Clinic Hours: | | | | | |
| Practice Operations | | | | | |
| Are you looking for a full or part-time physician? | | | | F/T | P/T |
| Do you have a walk-ins? | | | | Yes | No |
| Services | | | | | |
| Do you offer any special services at your clinic? If yes, what ones? | | | | Yes | No |
| Are medical procedures performed in your clinic? | | | | Yes | No |
| Daily Practice | | | | | |
| What are your clinic appointment times? | | | | | |
| Do you use an EMR? If so, which one? _____ | | | | Yes | No |
| Physician Preference/Practice Style | | | | | |
| Any special language requirements? (please state if so) | | | | | |
| Are there areas of special interest in your clinic? (such as sports med, geriatrics, obstetrics) | | | | | |
| The team | | | | | |
| What type of staff and allied health professionals do you have in your clinic? | | | | | |
| MOA | Yes | No | HMN | Yes | No |
| Receptionist | Yes | No | Pharmacist | Yes | No |
| RN/LPN | Yes | No | Other: (please state) | | |
| BHC | Yes | No | | | |
| Vacation | | | | | |
| Do you have locum coverage or does the physician find his/her own locum? | | | | | |
| Other (comments): | | | | | |
| Patient Panel | | | | | |
| 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: _____ | | |
| Additional comments: | | | | | |