

Questionnaire (Please type into this form)

Clinic Details

Clinic Name: _____

Clinic Address: _____

Clinic Hours: _____

Practice Needs

Are you looking for a full or part-time physician?	F/T	P/T	Either
Does your clinic see walk-in patients?	No	Yes	
Any special language requirements?	No	Yes, please specify	
Any special services at your clinic?	No	Yes, please specify	
Are medical procedures performed in your clinic?	No	Yes, please specify	
Which EMR is used in your clinic?	Paper Charts		
Does your clinic offer:	Virtual Appointments	Secure Messaging	Online Booking
Any areas of special interest in your clinic? (ie. Sports Med, geriatrics, obstetrics)	No	Yes, please specify:	

Would you like the physician to:

(Please check all that apply)

Take on new patients	Bring their own panel	Take over an existing panel
Locum coverage for absences is the responsibility of:	The clinic	The physician

The Clinic Team

What team members are in your clinic?

MOA	Health Management Nurse	Other: (please specify)
Receptionist	Pharmacist	
RN/LPN	Behavioural Health Consultant	
Nurse Practitioner	Panel Manager	

Other (comments):

Clinic contact person for physician to contact: _____

Phone: _____ Email: _____

Additional comments:
