Clinic Seeking Locum Physician

Questionnaire (Please print legibly or type into this form)

Date Submitted:

Clinic Details

Clinic Name:

Clinic Address:

Clinic Hours:

Practice Needs

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 Check all that apply

Any areas of special interest in your clinic? (ie. Sports Med, geriatrics, obstetrics) ◯ No ◯ Yes, please specify:

Dates locum is required:

The Clinic Team

What team members are in your clinic?

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

Other (comments):

Clinic contact person for physician to contact:

Phone: Email:

Additional comments:

Email this form to Membership at membership@cfpcn.ca