Clinic Seeking Physician

Questionnaire (Please print legibly or type into this form)

Date Submitted:

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 Check all that apply

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
☐ 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