Clinic Seeking **Locum Physician**

Questionnaire (Please print legibly or type into this form)

Clinic details

Clinic name: Date submitted:

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 (check all that apply): ☐ Virtual appointments ☐ Secure messaging ☐ Online booking

Any areas of special interest in your clinic? (i.e., sports med, geriatrics, obstetrics) ◯ No ◯ Yes, please specify:

Dates locum is required:

The clinic team

What team members are in your clinic? Check all the apply.

☐ MOA
☐ Receptionist
☐ LPN
☐ Nurse Practitioner
☐ Registered Nurse
☐ Pharmacist
☐ Behavioural Health Consultant
☐ EMR Specialist
☐ 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.

Clear form