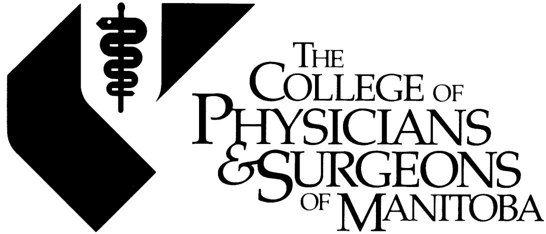


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## Quality Improvement Program
## Pre-Screening Questionnaire

Name:_________________________________________ Date of Birth (dd/mm/yyyy):____________________

Address:__________________________________________________________________________________

Phone:___________________________ Fax:_____________________ Email:___________________________

University of medical degree: ___________________________________________________ Year: __________

Year internship/residency completed: __________ Type of training: ___________________________________

Please describe your practice (field of practice, full or part time, number of hours/week, number of patients/cases per week):

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Is your practice: office based___ hospital based ____

How many years have you been in your current practice? ____________

Are you currently on medical/maternity leave? (Y/N) ____ Expected date of return (dd/mm/yyyy):____________

Do you plan to retire within the next twelve months? (Y/N) ___ Planned date (dd/mm/yyyy): _______________

Have you been assessed during the last five years for licensure, certification, or other reasons (i.e., full medical license in Canada, certification by the Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada) ___________________________________________________________________________

If **yes**, please provide details including date:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Any additional information you would like to provide may be noted below:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

__________________________________ ___________________________________
Signature Date

We gratefully acknowledge the Atlantic Provinces Medical Review Program for allowing the adaptation of this form.