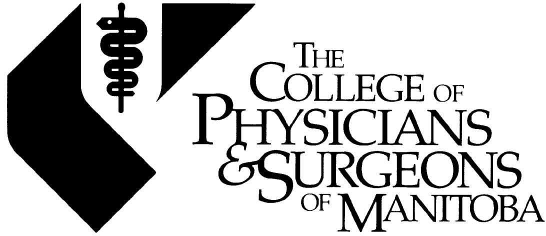

1000-1661 PORTAGE AVENUE WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
EMAIL: QUALITY@CPSM.MB.CA

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 **maternity leave**? (Y/N) ____ Expected date of return (dd/mm/yyyy):____________

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

☐ I will be retiring from the practice of medicine in the next 6 months

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), or in the past five years have you been the subject of a College review?

____

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.

April 2020