THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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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.