

Please help us update our records by completing the following information:

Section One: General Information

1. Name:

First Name: _____ Last Name: _____
Maiden Name: _____

2. Practice Address:

Street: _____
City: _____
Postal Code: _____

3. Mailing Address: Same as Above

If different:

Street: _____
City: _____
Postal Code: _____

4. Contact Information

Office Phone Number: _____ Preferred Method of Contact
Office Fax Number: _____ Preferred Method of Contact
Alt. Phone Number: _____ Preferred Method of Contact
E-mail Address: _____ Preferred Method of Contact

6. Are you a Corporation?

Yes No Corporation Name: _____

7. Please provide your SIN number: _____

Section Two: Medical Information

1. Where did you complete your Medical Training?

Medical School: _____
Residency University: _____
Secondary Residency University: _____

Please help us update our records by completing the following information:

2. In what year did you complete your Medical Degree? _____

3. What is your CPSO Number? _____

4. Please identify what certificates that you have: (check all that apply)

CCFP CCFP (EM) CCFP (Anes) FRCS FRCP RCPSC RCPS
MBBA None Other _____

5. Did you complete a ROMP rotation as a medical trainee? Yes No

Section Three: Practice Information

1. Please indicate your specialty:

- | | | |
|---|--|---|
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Endocrinology & Metabolism | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Family Medicine (EM) | <input type="checkbox"/> Forensic Pathology | <input type="checkbox"/> Orthopedic Surgery |
| <input type="checkbox"/> Family Medicine (Anes) | <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Otolaryncology |
| <input type="checkbox"/> Adolescent Medicine | <input type="checkbox"/> General Pathology | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Anatomical Pathology | <input type="checkbox"/> Geriatrics/Gerontology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Anesthesiology (Royal College) | <input type="checkbox"/> Hematology | <input type="checkbox"/> Respiriology |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Hospitalist (FM) | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Hospitalist (IM) | <input type="checkbox"/> Physical Medicine & Rehab |
| <input type="checkbox"/> Clinical Immunology & Allergy | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Clinical Pharmacology | <input type="checkbox"/> Internal Medicine (General) | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Community Medicine | <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Colorectal Surgery | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Transfusion Medicine |
| <input type="checkbox"/> Critical Care Medicine | <input type="checkbox"/> Neurology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Developmental Pediatrics | <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Obstetrics and Gynecology | <div style="border: 1px solid black; padding: 5px;">If Other, please specify:</div> |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Nuclear Medicine | |

Please help us update our records by completing the following information:

2. Please indicate the focus of your practice:

- | | | |
|---|---|--|
| <input type="checkbox"/> Aboriginal Medicine | <input type="checkbox"/> Diabetes Research | <input type="checkbox"/> Nerve Regeneration |
| <input type="checkbox"/> Acute Pain | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Addiction Medicine | <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Preventative Medicine |
| <input type="checkbox"/> Adolescent Medicine | <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Adolescent Psychology | <input type="checkbox"/> Environmental Health | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Adult ADHD | <input type="checkbox"/> Forensic Medicine | <input type="checkbox"/> Sexual Health/Assault |
| <input type="checkbox"/> Allopathic Medicine | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Stroke Rehabilitation |
| <input type="checkbox"/> Child Psychology | <input type="checkbox"/> Health Promotion | <input type="checkbox"/> Thoracic Surgery |
| <input type="checkbox"/> Coroner's work | <input type="checkbox"/> High Risk Obstetrics | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Cosmetic Treatments | <input type="checkbox"/> Hip/Knee Revision | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Infertility | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Cytology | <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Mood Disorders | If other, please specify: |
| <input type="checkbox"/> Developmental & Behavioural Pediatrics | <input type="checkbox"/> Neonatology | |

3. Please indicate the hospitals within the ROMP Region where you hold active hospital privileges: *(Please indicate your primary hospital privileges with a "P", and check all hospitals where you hold active privileges)*

- | | | |
|---|--|--|
| <input type="checkbox"/> Brant Community Healthcare | <input type="checkbox"/> Homewood Health Centre | <input type="checkbox"/> Northumberland Hills Hospital |
| <input type="checkbox"/> Cambridge Memorial Hospital | <input type="checkbox"/> LHC - Bowmanville Hospital | <input type="checkbox"/> Orillia Soldiers' Memorial Hospital |
| <input type="checkbox"/> Campbelford Memorial Hospital | <input type="checkbox"/> LHC - Port Perry Hospital | <input type="checkbox"/> Palmerston and District Hospital |
| <input type="checkbox"/> Collingwood G&M Hospital | <input type="checkbox"/> Louise Marshall Hospital | <input type="checkbox"/> Peterborough Regional Hospital |
| <input type="checkbox"/> GBHS - Markdale Hospital | <input type="checkbox"/> Mental Health Centre
Penetanguishene | <input type="checkbox"/> Ross Memorial Hospital |
| <input type="checkbox"/> GBHS - Meaford Hospital | <input type="checkbox"/> MSHC - Markham Hospital | <input type="checkbox"/> Royal Victoria Hospital |
| <input type="checkbox"/> GBHS - Owen Sound Hospital | <input type="checkbox"/> MSHC - Uxbridge Hospital | <input type="checkbox"/> Southlake Regional Hospital |
| <input type="checkbox"/> Grand River Hospital | <input type="checkbox"/> NHS - Douglas Memorial Hospital | <input type="checkbox"/> Shelburne District Hospital |
| <input type="checkbox"/> Groves Memorial Hospital | <input type="checkbox"/> NHS - Greater Niagara Hospital | <input type="checkbox"/> St. Mary's Hospital |
| <input type="checkbox"/> Guelph General Hospital | <input type="checkbox"/> NHS - Niagara-on-the-Lake Site | <input type="checkbox"/> Stevenson Memorial Hospital |
| <input type="checkbox"/> Haldimand War Memorial | <input type="checkbox"/> NHS - Port Colborne General | <input type="checkbox"/> West Haldimand General Hospital |
| <input type="checkbox"/> HHHS - Haliburton | <input type="checkbox"/> NHS - St. Catharines General | <input type="checkbox"/> West Lincoln Memorial Hospital |
| <input type="checkbox"/> HHHS - Midland | <input type="checkbox"/> NHS - Ontario Street Site | <input type="checkbox"/> No hospital privileges |
| <input type="checkbox"/> HHS - Georgetown | <input type="checkbox"/> NHS - Welland General | |
| <input type="checkbox"/> HHS - Milton District Hospital | <input type="checkbox"/> NSHA - Penetanguishene General | |
| <input type="checkbox"/> Headwaters Health Care | <input type="checkbox"/> Norfolk General Hospital | |

Please help us update our records by completing the following information:

3. What is the distance between your office and the hospital where you hold your primary privileges?

No Office Office in Hospital 0 – 5km 6 – 15km 16 – 20km Over 25 km

4. Please indicate the percentage of time spent in:

	0 %	1 – 20%	21 – 40%	41 – 50%	51 – 60%	61 – 80%	81 – 99%	100%
Hospital								
Office								
LTC								

5. My hospital work is divided between: (please check)

	Daily	Weekly	Multiple Times a Month	Rarely	Never
In Patient Care					
Emergency Room Shifts					
Elective Surgery					

6. Please indicate your patient profile:

Mostly Men Mostly Women Mixture of Men & Women
 Mostly Children Mostly Adults Mostly Seniors Mixture of all ages
 Aboriginal Medicine Francophone Medicine Home Visits Nursing Home Visits

7. Are you part of a:

CHC FHN FHT Group Practice Solo Practice Other

8. Do you share teaching amongst your colleagues? Yes No

9. If you share teaching, please list the other physician with whom you teach:

Physician's Name: _____ Physician's Name: _____

Physician's Name: _____ Physician's Name: _____

Physician's Name: _____ Physician's Name: _____

Please help us update our records by completing the following information:

10. Are you comfortable teaching in French? Yes No

11. Do you use video conferencing:

	Yes	No
In your office?	<input type="checkbox"/>	<input type="checkbox"/>
At the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
At the FHT?	<input type="checkbox"/>	<input type="checkbox"/>
At the CHC?	<input type="checkbox"/>	<input type="checkbox"/>
For patient consultations?	<input type="checkbox"/>	<input type="checkbox"/>
For educational sessions?	<input type="checkbox"/>	<input type="checkbox"/>

Section Four: Faculty Appointment

1. If you have a current Faculty Appointment, please indicate at what University:

- Northern Ontario School of Medicine
- McMaster University
- Queen's University
- University of Toronto
- University of Ottawa
- University of Western Ontario

2. Please indicate the date of your appointment renewal: _____

3. Please indicate the term of your Faculty Appointment: _____

4. If you do not have an existing Faculty Appointment and would like one, please indicate at what university:

- Northern Ontario School of Medicine
- McMaster University
- Queen's University
- University of Toronto
- University of Ottawa
- University of Western Ontario