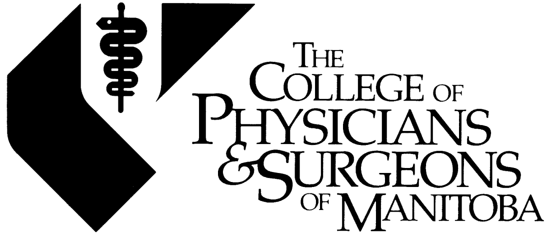

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EMAIL: QUALITY@CPSM.MB.CA

Quality Improvement Program
Pre-Screening Questionnaire

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

Phone:___________________________ Fax:_____________________ Email:____________________________

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 **parental leave** ? No ☐ Yes ☐
Expected date of return (dd/mm/yyyy):______________________

Are you currently on **medical leave**? No ☐ Yes ☐ 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 regulatory college review? Have you done a Practice Learning Plan with the CFPC, or participated in any Section 3: Assessment activities of the RCPSC? If these activities include reflection on your practice and a learning or improvement plan, they may be deemed as meeting the requirements of the Quality Improvement Program.

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