The Atlantic Provinces
Medical Peer Review

APMPR Assessment Pre-Screening

Name: _____ Date of Birth _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Medical degree from University of _____ 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 _____ Language of files: E ____ F ____

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

Are you currently on medical/maternity leave? _____ Expected date of return: _____

Do you plan to retire within the next twelve months? _____ Planned date _____

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, or College of Family Physicians)? ____

If yes, please provide details including date: _____

_____

_____

_____

Is there any reason you believe that you may not qualify for peer review? _____

_____

_____

_____ _____

Signature Date