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?

☐ My Electronic Signature* Date: _____

**by placing a check mark in the "My Electronic Signature", you verify that the information provided on this questionnaire is correct, true and accurate.*

Clear Form **Print** **Save**

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