CPSNL
Physician Peer Review Program (PPR-NL)

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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 (tick one): 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), or in the past five years have you been the subject of a College review? (Y/N) ___

If **yes**, please provide details including date:

Any additional information you would like to provide may be noted below:

_____ _____

Name **Date**