Provincial Locum Recruitment Program

Locum Opportunity Intake Form

HOST PHYSICIAN INFORMATION

Surname: Given Name: Initial:

Current Mailing Address: Provider Number:

Telephone: Email:

LOCUM SERVICES REQUIRED

Practice location:

Dates:

ADDITIONAL DETAILS:

Overhead that will be charged to the locum (dollar amount or percentage of billings)

Are third-party billings (Workplace NL, driver's medicals, insurance forms, etc.) included in overhead (Y/N)

Are uninsured services provided (Y/N)

How are they charged to patients?

Information on how billings are submitted

ADDITIONAL DETAILS CONTINUED:

Expected service hours/days at the clinic

Settings the locum will be expected to cover:

- [ ] Clinic
- [ ] Long-term care
- [ ] Palliative care
- [ ] After-hours clinics
- [ ] On-call obligations
- [ ] House calls (indicate travel obligations)
- [ ] Other

Number of physicians at the practice

Specialized skills offered at the practice

Typical patient volume per day/week

Special patient populations served (including considerations for these populations)

Virtual care appointments offered at the clinic (Y/N)

Electronic Medical Record implemented (Y/N)

Additional tasks/responsibilities to be assumed by the locum

Expectations for issuing prescriptions (note that this will be dependent on the comfort level of the locum and can be patient-dependent)

Narcotics/controlled substances prescribed (Y/N)

Contact information for clinic administrative staff

Any other relevant information/directions

DECLARATION BY APPLICANT

I certify that all information given on this application is complete and true to the best of my knowledge.

I acknowledge that the Department of Health and Community Services is collecting the information contained in and included with this form for the purposes of establishment and maintenance of a provincial physician locum roster, designed to attract qualified physician locums to provide health care services in the Province of Newfoundland and Labrador. I authorize the Department to collect my personal information and to use and disclose such information to other parties as it considers necessary for the purposes of establishment and maintenance of a provincial physician locum roster and assessing the efficacy of this program.

I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate removal from the provincial physician locum roster. The Department of Health and Community Services has my consent to the collection, use and disclosure of my personal information in accordance with section 61(c) of the **Access to Information and Protection of Privacy Act, 2015**.

Should you have any questions about the collection, use or retention of your personal information, please contact MedServicesPrograms@gov.nl.ca.

Applicant Signature: Date:

Please do not include any unnecessary personal information when submitting this application.

COMPLETED APPLICATIONS CAN BE RETURNED VIA MAIL OR EMAIL TO:

Medical Services Division
Department of Health and Community Services
1st Floor, West Block, Confederation Building
P.O. Box 8700, St. John's, NL A1B 4J6
MedServicesPrograms@gov.nl.ca