

Locum Physician Evaluation

(Completion required for locum physician payment)

HealthForceOntario
Rural Family Medicine Locum Program



Assignment No.: _____

Locum Physician Name: _____ CPSO No.: _____

Community or Rural Family Physician Name: _____

Assignment Dates: From (yy/mm/dd) _____ To (yy/mm/dd) _____

Total Days Worked in Assignment: _____

Where did you provide locum services (check all that apply)?

Office General Hospital Long Term Care Home Other: _____

Prior to the assignment, did you receive adequate information on the following:

Assignment Dates	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments: _____
Directions to Assignment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments: _____
Community Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments: _____
Community Information	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments: _____
Accommodation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments: _____

	Very Satisfied	Satisfied	Not Satisfied
Were you satisfied with the hospital staff support?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you satisfied with the office staff support?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you satisfied with the accommodations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Would you accept another assignment in the practice? Yes No

Please provide any information you feel would improve the program: _____

Locum Physician Signature: _____ Date: _____

I would like to receive the end of locum assignment package via:

Regular mail Email. (Please provide your email address _____)

I prefer not to be notified and will access the applicable form(s) online.

HealthForceOntario Marketing and Recruitment Agency Rural Family Medicine Locum Program

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