



The Foundation for Medical Practice Education
McMaster University
 1280 Main Street West, DTC Basement Level
 Hamilton, Ontario L8S 4L8
 Canada

For further information, please contact The Foundation at:
 Telephone: (905) 525-9140, ext. 22219
 Toll-free: 1-800-661-3249
 Fax: (905) 540-4988
 E-mail: fmpe@mcmaster.ca
 Website: www.fmpe.org

PBSG MEMBERSHIP REGISTRATION FORM

Please complete both sides of this form.

PRACTICE BASED SMALL GROUP (PBSG) LEARNING PROGRAM

Amount Due:

Canada: **CDN\$325.00**
 USA/Mexico*: **CDN\$340.00**
 International*: **CDN\$355.00**
**includes shipping costs*

Please choose one of the following:

New member **Renewing member**

Indicate the start date of your group:

January **September**

Facilitator Name: _____

Date of first attendance at a group meeting: _____

Please call us if you are joining a group already in session, to see if you qualify for a pro-rated membership fee.

Contact Information

Please indicate your language preference: English French Gender: Male Female
 Designation: MD MD—Emergency only NP/RN(EC) RN Other _____

PLEASE PRINT

Name: _____

Preferred Mailing Address: home work _____

Alternate Mailing Address (optional): _____

City: _____

City: _____

Province/State: _____

Province/State: _____

Postal/Zip Code: _____

Postal/Zip Code: _____

Country: _____

Country: _____

Work Phone: (general) (_____) _____

Fax: (_____) _____

(private) (_____) _____

E-mail: _____

Home Phone: (_____) _____

Fax: (_____) _____

E-mail: _____

Payment Information

Cheque enclosed (payable in Canadian funds only
 to The Foundation for Medical Practice Education)

Visa MasterCard Amount: _____

Card #: _____

Exp.: _____ Signature: _____

The Foundation for Medical Practice Education (FMPE) is committed to protecting the privacy of all individuals (members and non-members) who interact in any way with the FMPE and its Practice-Based Learning Programs. Please go to www.fmpe.org/en/documents/privacy.html for a copy of our privacy policy.

Please contact your provincial chapter of the Canadian Medical Association for information on eligibility for reimbursement.

(please turn over)



The Foundation for Medical Practice Education
*We would appreciate your taking the time to complete this form
 and fax it to us at 905-540-4988*

DEMOGRAPHIC DATA FORM (please print)

Name _____

How did you learn about the Practice Based Learning Programs?

- Brochure Word of mouth Other _____
 Conferences/Workshops CFPC

1. Designation: MD MD—Emergency only NP/RN(EC) RN Other _____

2. From which university did you receive your:

Undergraduate medical training? _____

Postgraduate medical training? _____

Other medical training? _____

3. Year of medical school graduation:

4. Year of birth (optional):

- before 1940 1940-1949 1950-1959 1960-1969 1970-1979 1980-1989

5. Years in practice: 1-10 11-20 21-30 >30

6. Certification: CCFP other:

7. Gender: Male Female

8. Population primarily served by your practice (please check one):

- inner city rural
 urban/suburban geographically isolated/remote
 small town other (please describe):

9. Clinical hours: full-time part-time

10. Estimated number of clinical hours worked per week

11. Types of practice (please check the term from **each** column that best describes your practice):

- | | | |
|--------------------------------------|--|---|
| (a) <input type="checkbox"/> solo | (b) <input type="checkbox"/> fee for service | (c) <input type="checkbox"/> private office |
| <input type="checkbox"/> partnership | <input type="checkbox"/> capitation (e.g. HSO) | <input type="checkbox"/> community clinic |
| <input type="checkbox"/> group | <input type="checkbox"/> salaried | <input type="checkbox"/> walk-in clinic |
| <input type="checkbox"/> other | <input type="checkbox"/> other | <input type="checkbox"/> other |

12. Scope of practice (please check any of the following that are regular components of your practice):

- | | | |
|---|---|--|
| <input type="checkbox"/> care of children | <input type="checkbox"/> pregnancy/intrapartum care | <input type="checkbox"/> psychotherapy/counselling |
| <input type="checkbox"/> office procedures | <input type="checkbox"/> palliative care | <input type="checkbox"/> emergency medicine |
| <input type="checkbox"/> in-patient hospital care | <input type="checkbox"/> nursing home care | <input type="checkbox"/> academic teaching |
| <input type="checkbox"/> electronic medical records | <input type="checkbox"/> internet/electronic information system | <input type="checkbox"/> PDA/Palm Pilot |

13. Areas of special interest?

14. Interested in CME research? yes no

15. Other CME events you have attended in the past year:

How many hours/year (on average)?

	none	1-5	6-10	11-15	16-20
Local hospital rounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
University accredited CME programs/courses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CFPC Scientific Assemblies—provincial or national	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other conferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CME programs sponsored by pharmaceutical company	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-study programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CME programs on the internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Would you be interested in receiving e-mail notifications regarding our programs/organization? yes no

e-mail address: _____