



**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](mailto:fmpe@mcmaster.ca)  
 Website: [www.fmpe.org](http://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\$310.00**  
 USA / Mexico\*: **CDN\$325.00**  
 International\*: **CDN\$340.00**  
*\*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](http://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                       1980-1985

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