

INTERPRETING PHYSICIAN

(This section must be completed by ALL affiliated physicians *other than* the Quality Advisor)

Surname (as given on CPSO register):			
Given name(s) (as given on CPSO register):			
CPSO #			
Year Speciality obtained (dd/mm/yyyy):			
Royal College of Physicians and Surgeons of Canada Fellowship:		Yes	No
Speciality:	Yes	No	Please List:

CONTACT INFORMATION			
Facility Name and IHF Billing #			
Facility Address:			
Email:		Office Phone:	
Direct Phone:		Fax:	

What services (e.g. interpreting consultation) do you currently provide within the IHF?			
Do you have regular contact and interaction with peers?	Yes	No	(pick one)
Have you chosen to focus, subspecialize or restrict your practice?	Yes	No	(pick one)
If yes, please specify			

Do you have regular contact and interaction with referring clinicians and specialists?	Yes	No	<i>(pick one)</i>
Do you have regular contact and interaction with the Licensee?	Yes	No	<i>(pick one)</i>

Where do you report?	Onsite	Offsite	If offsite, where, (e.g. Home, Hospital)	
If offsite, describe your interpreting workstation(s) setup. (# of monitors (colour vs BW), resolution (e.g. 3 MP/5MP).				

Please indicate the types of examinations that you perform/interpret in a typical work-week at this facility:	
Examination Categories	# of examinations read or procedures performed
Computed Tomography	
Magnetic Resonance Imaging	

Please identify other facilities for which you provide interpreting services but are NOT the Quality Advisor (if applicable).			
Facility Name:		Billing #	
Facility Name:		Billing #	
Facility Name:		Billing #	