

**Peer Assessment Committee**  
**College of Physicians and Surgeons of New Brunswick**



**Peer Assessment Committee (PAC) Physician Profile**

Name: \_\_\_\_\_ Year of Birth \_\_\_\_\_

Contact Address: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Office phone number: \_\_\_\_\_ Home or cell phone: \_\_\_\_\_

\*\* E-mail: \_\_\_\_\_ (REQUIRED)

Medical degree from University of \_\_\_\_\_ Year \_\_\_\_\_

Year internship/residency completed \_\_\_\_\_ Field/Specialty: \_\_\_\_\_

Are you on medical/maternity/sabbatical leave? \_\_\_\_\_ Expected date of return: \_\_\_\_\_

Do you plan to retire within the next twelve months? \_\_\_\_\_ Planned date \_\_\_\_\_

Please describe your practice (field of practice; full or part time; number of hours/week):

\_\_\_\_\_  
\_\_\_\_\_

How many years have you been in your current practice? \_\_\_\_\_

Preferred Language of Correspondence: E \_\_\_ F \_\_\_ Language of patient charts: E \_\_\_ F \_\_\_

Are your patient charts: Paper \_\_\_ EMR \_\_\_ Name of EMR program: \_\_\_\_\_

Is your practice primarily: Office-based \_\_\_ Hospital-based \_\_\_\_\_?

Is your practice: Group \_\_\_ Solo \_\_\_\_\_

*(A group practice is one in which there are two or more doctors who share facilities, support staff or other resources)*

If you're in a group practice, please briefly describe how resources (staff or equipment) are shared in order to provide patient care:

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Do you have residents or other medical students in your practice: \_\_\_\_\_ If yes, how often and for how long: \_\_\_\_\_

How many patients/cases do you see in an average week: \_\_\_\_\_ per \_\_\_\_\_ hours of work

Do you provide hospital inpatient care? \_\_\_\_\_

If yes, please describe provisions for their care (i.e. hospitalist program or call schedule)

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Total CPD credits reported to your College (CFPC, Royal College) or to your health authority in the last year: \_\_\_\_\_

Have you been assessed during the last five-years for licensure, certification or other reasons (i.e. full medical license in Canada, certification by the Royal College, or College of Family Physicians)? \_\_\_\_\_

If yes, please provide details including date:

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I certify the information provided above is correct and complete.

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Signature

Date

**Thank you for your cooperation with the Peer Assessment Committee.**