



Health Human Resources Data Collection

FULL NAME: _____	DATE: _____
DESIGNATION: _____ HOME PHONE: (____) _____ - _____	FOR OFFICE USE:
EMAIL: _____	
HOME ADDRESS: _____	
CITY: _____ PROV: _____ PC: _____	

ETHNICITY: <input type="checkbox"/> FIRST NATIONS <input type="checkbox"/> METIS <input type="checkbox"/> INUIT <input type="checkbox"/> OTHER _____	YEAR OF BIRTH: _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PRIMARY LANGUAGE: _____	2nd LANGUAGE: _____
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<input type="checkbox"/> PHYSICIAN <input type="checkbox"/> RESIDENT <input type="checkbox"/> STUDENT	MEDICAL SCHOOL: _____
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YEAR OF GRADUATION: _____	SPECIALTY: _____
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LOCATION OF PRACTISE: _____

CHANGE IN PRACTISE OR PRACTISE LOCATION IN PAST 5 YEARS: Yes No
 If yes, list previous practice location: _____

REASON FOR CHANGE IN PRACTISE: _____

CURRENT PRACTISE ELEMENTS (e.g. Clinician, Researcher, Medical Educator, Management):

1. _____
2. _____
3. _____
4. _____