Submit by Email

CPCSSN RCSSSP
Canadian Primary Care Sentinel Surveillance Network
Réseau canadien de surveillance sentinelle en soins primaires

CPCSSN / MaPCReN Provider Profile

Name: _____ Date: _____

Email Address: _____

1. Gender ☐ Male ☐ Female

2. What is your month and year of birth? (eg. July 1975) | |

3. Are you a: ☐ Family Physician ☐ Nurse Practitioner ☐ Pediatrician ☐ Other_____
Area of Specialty (if applicable):_____

4. In which country did you complete your undergraduate medical education?
☐ Canada ☐ International medical graduate

5. In what year did you complete your undergraduate medical education? _____

6. Which postgraduate certification do you possess? ☐ RCPSC ☐ CFPC ☐ Other _____

7. What year did you complete your postgraduate certification? _____

In what city/country did you complete your residency? _____

8. Under which model are you funded? ☐ Fee for Service ☐ Salary / Alternate Funding

MaPCReN
Manitoba Primary Care Research Network