Physician Departure Form

To help us better understand your work environment and opportunities to how to improve as an organization we are requesting that you complete the physician exit survey here. Completion of the survey should take approximately 10 minutes and **all information is held in strict confidence and is used for summary results, not on an individual basis.**

If you are planning to change, depart or close your medical practice i.e. retirement, relocation to another geographical location outside current patient population area, illness, or other reason, please complete the following **Physician Departure Form** as soon as possible to assist the Department Head (DH) to engage in advance planning to manage the pending vacancy.

Please submit completed forms to the Department Head in your zone.

1. PHYSICIAN INFORMATION

Departing Physician Name: _____ Departure Date* _____
Full Time / Part Time: _____ Reason for Leaving: _____
Physician Contact Information:
Email:_____
Phone Number:_____

**if you are still working through actual departure date please provide an estimated departure date.*

2. SERVICE PROFILE

What are the range of services you provide outside of your practice – please check all that apply:

☐ Emergency Room Coverage
If yes, what facility (s) _____

☐ Inpatient
If yes, what facility (s) _____

☐ Long Term Care
If yes, what facility (s) _____

☐ Other, please specify _____

3. PRACTICE INFORMATION

i. Practice Type

☐ Solo ☐ Group

Estimated practice size _____

ii. EMR

☐ Yes ☐ No

If yes, which EMR _____

iii. Do you have a Physician who has expressed interest in taking over your practice?

☐ Yes ☐ No

If yes, interested Physician_____

If you have any questions please email: NSHANewMDCommittee@nshealth.ca