Victoria
Division of Family Practice
A GPSC initiative

# Victoria Practice Coverage -Permanent

## Job Posting Submission

Position Title _____ _____

Start Date _____ End Date (if applicable) _____

**GP/PRACTICE INFORMATION**

☐ Solo Practice ☐ Group Practice ☐ Combination ☐ Walk-in Clinic

Practice Name _____

If you work at a walk-in-clinic, please name your medical director _____

GP Name(s) _____

Street Address (Suite/Number/Street) _____

City _____ Postal Code _____

Tel (office) _____ Tel (mobile) _____

Fax _____ Email _____

Are you a member of the Victoria Division of Family Practice? ☐ Yes ☐ No

**POSTING STATUS** — please check ☑ all boxes that apply

☐ Permanent ☐ Full-time ☐ Part-time ☐ Other (e.g. retirement/long-term associate/lengthy leave)

☐ Will consider cross-coverage options

**POSTING DESCRIPTION — MANDATORY—** describe the practice/position in detail; include patient demographics, practice type and any special considerations.

_____

_____

_____

_____

_____

Average daily patient volume _____ EMR? ☐ No ☐ Yes → EMR Name _____

PLEASE CONTINUE TO NEXT PAGE →

Victoria
Division of Family Practice
A GPSC initiative

# Victoria Practice Coverage -Permanent

**POSTING REQUIREMENTS —** please check ☑ all boxes that apply

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| On-call obligations | ☐ n/a | ☐ Required | ☐ Optional | Telephone on-call | ☐ n/a | ☐ Required | ☐ Optional |
| Hospital inpatients | ☐ n/a | ☐ Required | ☐ Optional | Obstetrics | ☐ n/a | ☐ Required | ☐ Optional |
| Nursing home/extended care | ☐ n/a | ☐ Required | ☐ Optional | House calls | ☐ n/a | ☐ Required | ☐ Optional |
| Surgical assists | ☐ n/a | ☐ Required | ☐ Optional | ER work | ☐ n/a | ☐ Required | ☐ Optional |
| ACLS | ☐ n/a | ☐ Required | ☐ Optional | ATLS | ☐ n/a | ☐ Required | ☐ Optional |

Other _____

**SCHEDULE —** (day & times, if applicable)

☐ **Mo**_____**to** _____ ☐ **Tu**_____**to** _____ ☐ **We**_____**to** _____ ☐ **Th**_____**to** _____

☐ **Fr**_____**to** _____ ☐ **Sa**_____**to** _____ ☐ **Su**_____**to** _____ ☐ **Work hours are flexible**

Describe your work environment (e.g. how any clinic rooms, MOA, RNs, etc.)_____

| | | | | | |
|---|---|---|---|---|---|
| Dedicated computer for physician use? | ☐ Yes | ☐ No | Wireless internet? | ☐ Yes | ☐ No |
| High speed internet? | ☐ Yes | ☐ No | Parking available for physician | ☐ Yes | ☐ No |

Parking information (e.g. indicate if free) _____

OTHER COMMENTS/NEEDS _____

**CONTACT — If you would like to be contacted directly** please complete if contact information is different from GP/Practice Information already completed above, otherwise all inquires will be fielded by the Victoria Division of Family Practice.

Name _____ Telephone _____

Email _____

** Please note this posting will be listed on the public side of the Victoria Division website.*

**EMAIL** jbeerenparsons@divisionsbc.ca | **WEB** divisionsbc.ca/victoria