White Rock-South Surrey
Division of Family Practice
A GPSC initiative

LOCUM REQUEST FORM

Doctor Name:	**Practice/Clinic Name:**
Contact Person:	**Contact Phone Number:**
Contact Email:	

Time period for Locum Coverage (Start and end date, m/d/yy): _____ **to** _____

Additional dates if applicable (m/d/yy): _____ to _____

Please specify days and hours:

	Week 1			**Week 2**		
	Full day	**AM Only**	**PM Only**	**Full day**	**AM Only**	**PM Only**
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
If hours differ for subsequent weeks, note here:						

Open to part-time coverage?	☐ Yes ☐ No
Average number of patients seen per day:	
Split for locum (ex. 70/30):	
Parking available:	☐ Pay parking ☐ Free parking

Save this form to your computer, then email to info@wrssdivision.ca or fax to 604.417.2260

Division office use: Received By: *Date:*