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

LOCUM REQUEST FORM

Name: ____

Practice Name: ____

Contact person telephone number: ________________________________

Email address: ____

Requested Coverage Dates (please list all dates):

Please Specify Hours Requested:

HOURS REQUESTED:						
	Week 1			Week 2		
	Full day	AM Only	PM Only	Full day	AM Only	PM Only
Monday	-	-	-	-	-	-
Tuesday	-	-	-	-	-	-
Wednesday	-	-	-	-	-	-
Thursday	-	-	-	-	-	-
Friday	-	-	-	-	-	-

Open to part-time coverage?

____

Does your request include hospital coverage? YES / NO

Hospital coverage details: ____

Please send completed WRSS Locum Requests by email to:
kabelson@wrssdivision.ca or fax to **604.417.2260**

Average Number of Patients Seen per Day:

____

Compensation Type:

____

WIFI Available?

____

Parking Available?

____

Other Information for Advertising:

____

____

____

____

Received By: ______________________________________

Date: _______________________________

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