Collaborating Physician Expression of Interest

Name of Physician Group: _____________________________________________

Contact: ____________________________  Email: _______________________

Practice Model (Please check most applicable):

☐ BSM - Blended salary model
☐ CCM - Comprehensive care model
☐ FHG - Family health group
☐ FHN - Family health network
☐ FHO - Family health organization
☐ RNPG - Rural and Northern Physician Group
☐ FFS - Solofee-for-service
☐ FHT - Family Health Team
☐ Other, please specify: ____________________________________________

Number of Physicians in Practice (Estimate): __________________________