



PHYSICIAN DATA SHEET

(Please Print or Type All Information)

The information that you provide will be used to identify and alert you to those opportunities that may be of interest to you. Your CV will not be shared nor your availability posted on the MassAFP website without your knowledge and consent.

Please return the completed form to the MassAFP via Fax (978) 526-4417,
 Email (information@massafp.org) or
 US Mail: PO Box 1406, Manchester MA 01944

Name: _____ MD DO

Preferred Address: _____

Phones: Home: _____ Cell: _____ Office: _____

Pager: _____ Fax: _____ Other: _____

Email: _____ Date Available: _____

Preferred phone Home Office Cell. What is the best time to contact you? _____

Residency Program	City & State	Year of Completion

Medical School	Degree	Year of Graduation

Undergraduate	Degree	Year of Graduation

ABFM Certified Yes No Original Certification Date _____ Recertification _____

Fellowship Training Yes No Type of Fellowship: _____

Language Skills (indicate language) _____ Fluent Conversational Written

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Hours Desired: Full Time Part Time Either

Geographic Preference

Indicate Your Geographic & Practice Preferences in Numerical Order
 With 1 Being Your First Choice

Practice Preference

Practice Areas

Check Your Primary Areas of Practice Interest

Downtown Boston

Northern Boston Suburbs

Southern Boston Suburbs

Western Boston Suburbs

Northeastern Mass

Southeastern Mass

Central Mass

Western Mass

Community Health Center

Small FP Group (< 4)

Large FP Practice (5 >)

Multi-Specialty Group

Hospitalist

Urgent Care

Other

Geriatrics

Integrative Medicine

OB - Routine

OB - High Risk

Pediatrics

Research

Sports Medicine

Teaching

Urgent Care

Women's Health

Other