Member Enrollment Form

Date:

Information about you:

REQUIRED INFORMATION:

Name and Degree(s):

Do you see patients? ☐ Yes ☐ No

If yes, do you see children? ☐ Yes ☐ No Do you see OB patients? ☐ Yes ☐ No

What is your specialty?

☐ Family Medicine ☐ Pediatrics ☐ Other (please explain)

☐ Gen. Internal Medicine ☐ Research

Do you speak any other language well enough to communicate with patients? ☐ Yes ☐ No

CONTACT INFORMATION (REQUIRED):

Your primary practice address:

City: State: Postal Code:

Practice Telephone Number: Practice Fax Number:

Preferred Telephone Number: Preferred E-mail:

Contact person in your practice if you are not available:

Contact person's phone: E-mail:

DEMOGRAPHIC QUESTIONS (VOLUNTARY):

Please note this information is voluntary and will only be used for analyses of the demographics of our network. Information collected will be reported in an aggregate, unidentified format only.

What year did you begin practice in your field?

What is your gender? ☐ M ☐ F

What is your ethnicity: ☐ Hispanic or Latino

☐ Not Hispanic or Latino

What is your race: (check all that apply)

☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Decline to answer

Information about your practice/organization:

Practice name:

Practice type:

- ☐ Solo practice
- ☐ Family Practice Group
  (more than one family physician in the practice)
- ☐ Primary Care Only
- ☐ Multi-Specialty Group
  (primary and specialty physicians)
- ☐ Academic practice or Residency Program
- ☐ Community Health Center (FQHC)
- ☐ Other (please explain)

How many physicians are working within your practice?
(This includes: MD or DO)

How many clinicians are working within your practice?
(This includes: Non-MD/DO providers (ex. PhD psychologist, nurse, nurse midwife, advanced practice register nurse, physician assistant)

Who is the Majority owner of your practice?

- ☐ Self
- ☐ Hospital or Healthcare system
- ☐ Government entity
- ☐ Medical Group Practice
- ☐ Managed Care Org.
- ☐ Other (please explain)

Do you have an EHR (Electronic Health Record)? ☐ Yes ☐ No

Definition: The aggregate electronic record of health-related information on an individual that is *created and gathered cumulatively across more than one health care organization* and is managed and consulted by licensed clinicians and staff involved in the individual's health and care.

If no, do you plan to install an EHR in the next 24 months? ☐ Yes ☐ No ☐ Maybe

If yes, which EHR System do you utilize?

Do you use a software vendor for the extraction, aggregation and standardization of clinical data?

If yes, which one?

If no, do you have the ability to extract data from your EHR? ☐ Yes ☐ No

What EMR (Electronic Medical Record) do you utilize, if any?

Definition: The electronic record of health-related information on an individual that is created, gathered, managed, and consulted by licensed clinicians and staff from a *single organization* who are involved in the individual's health

Do you have a wireless internet connection?

☐ Yes ☐ Not currently, but plan to have access soon ☐ No, and do not plan on getting access

IRB Information:

Is your practice required to report to an IRB (Institutional Review Board)?

☐ Yes ☐ No ☐ Don't Know

Thank you for your interest in the AAFP National Research Network!
Please email your completed membership enrollment form to: Kaari Kittell @ kkittell@aafp.org