Member Enrollment Form

Today's 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 provide prental care? Yes No

What is your specialty?

Family Medicine Pediatrics Behavioral Health

Gen. Internal Medicine Research Other (please explain)

Are you engaged in research? Yes No

Do you speak any other language well enough to communicate with patients?

Yes

No

AREA(S) OF INTEREST:

CONTACT INFORMATION (REQUIRED):

Practice name:

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 (OPTIONAL):

AMA #

What year did you begin practicing 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 type:

Solo practice (1 clinician) Multi-Specialty Group

Small (2-3 clinicians) (primary and specialty physicians)

Moderate (3-5 clinicians)

Academic practice or Residency Program

Large (> 5 clinicians) Community Health Center (FQHC)

Family Practice Group Other (please explain)

(more than one family physician in the practice)

Primary Care Only

How many physicians are working within your practice?

MD

DO

What is their estimated # of days per week?

MD

DO

How many clinicians (non-MD/DO providers) are working within your practice?

behavioral health clinician dietitian care manager nurse

advanced practice register nurse PhD psychologist social worker clinical pharmacist physician assistant nurse midwife

What is their estimated # of days per week?

behavioral health clinician dietitian care manager nurse

advanced practice register nurse PhD psychologist social worker clinical pharmacist physician assistant nurse midwife

Other (please explain)

Who is the Majority owner of your practice?

Self Managed Care Org.
Hospital or Healthcare system Accountable Care Org.

Medical Group Practice

Government entity

IRB Information:

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

Yes No Don't Know

eNQUIRENet: A sub-network of the AAFP NRN utilizing electronic health record (EHR) data as the primary source of data collection. eNQUIRENet seeks to blend quality improvement, effectiveness and translational research in a data-driven learning environment.



- ◆ The entire practice must enroll to become a member of eNQUIRENet.
- As an eNQUIRENet member you will automatically be enrolled as an NRN member.

Do you have an EHR (Electronic Health Record) or EMR (Electronic Medical Record)? Yes No If no, do you plan to install an EHR/EMR in the next 24 months? Yes No Maybe If yes, which EHR/EMR System do you utilize?

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

Do you (or your staff) have the ability to extract data independently from your EHR/EMR? Yes No Do you have a wireless internet connection?

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

Thank you for your interest in the AAFP National Research Network!

Please email your completed membership enrollment form to: Kaari Van Auken at kvanauken@aafp.org