

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 prenatal 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)

Small (2-3 clinicians)

Moderate (3-5 clinicians)

Large (> 5 clinicians)

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?

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

Who is the Majority owner of your practice?

Self

Hospital or Healthcare system

Government entity

Medical Group Practice

Managed Care Org.

Accountable Care Org.

Other (please explain)

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