family medicine NB médecine familiale
Innovation • Collaboration • Care | Soins

Physician application form for Family Medicine New Brunswick

By completing and signing this form, each of the physicians below indicate that they have received information about Family Medicine New Brunswick (FMNB); and are applying to the Physician Stewardship Group (PSG) to participate in the Program; and they wish to practice with the other physicians who have signed this form as an FMNB group (a Group).

The FMNB model of family medicine involves the creation of groups of physicians who want to work together to deliver services as outlined under the FMNB Program. It involves:

- Rostering of patients, and completing a Patient Enrolment Form for patients in their practice;
- Working toward the provision of same- or next-day access for their patients;
- Use of the Provincial EMR, which will be shared with their Group;
- Offering extended-hours access to patients, shared with their Group;
- Working with service providers from FMNB to improve business elements of their practice;
- Reporting of process data captured through their EMR on access measures, and reporting of clinical data captured through their EMR for practice improvement, as analysed by FMNB;
- Satisfying existing requirements of their work as established by their Regional Health Authority, such as inpatient care arrangements already in place;
- Participating in the FMNB Payment Model; and
- Entering into a required form of agreement among the physicians in their Group (the Group Agreement).

Each physician confirms and acknowledges that:

- They have already enrolled for, or implemented, the Provincial EMR;
- They must participate in a Group, or cannot participate in the Program;
- They have received the Community Health Needs Assessment for their area; and
- In addition to this application, and after approval by the PSG to participate in the Program, they will have the opportunity to review and sign other documents related to the FMNB Program.

Date form completed: _____

Physician	Signature