Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

REQUEST FOR LOCUM

Date: _____ **Clinic Name:** _____

Physician Name: _____ **Clinic Phone #:** _____

Contact Name: _____ **Contact Email:** _____

Contact Alt Phone #: _____ **Clinic Fax #:** _____

Is your office on EMR? **YES** **NO** **Type:** _____

Do you have a process for managing After Hours Critical Results? **YES** **NO**

Dates Requested

_____ _____

_____ _____

_____ _____

***Please Note**: Locum requests are granted on a *first-come-first-served* basis. If you have requested long-term coverage (2 weeks max request) some time may be allocated to other physicians who have also made requests in order to share the resources fairly. All requests will be confirmed as soon as possible.

For WRHA office only

Date received: _____

☐ **Approved** ☐ **Tentatively approved** ☐ **Declined**

Comments: _____

_____

_____

Locum physician will contact you prior to your leave to discuss details of coverage.

Please Send Completed Form to
broberge@whra.mb.ca