

**Please complete this questionnaire if you are in your SECOND year of a two-year Family Medicine Residency Program at a Canadian University.**

**If you are not a second year family medicine resident, please indicate your status below.**

- ? First year family medicine resident
- ? Third year advanced skills family medicine training position
- ? Resident in a specialty other than family medicine
- ? Physician in practice
- ? Other

**A. Training**

**1. Please indicate your overall sense of satisfaction with your family medicine program.**

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Overall satisfaction with family medicine program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2.a) For the following experiences within your residency training, please indicate:**

- ?? **if the specific category of training is available to you (Please tick all that apply);**
- ?? **if available and you have experienced, please rate the training using the scale provided;**
- ?? **if you feel that the specific category of training should be a mandatory component of your residency curriculum.**

	Available?	Rating					Should it be Mandatory?
		1(poor)	2	3	4	5(excellent)	
Family Medicine rotations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aboriginal health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternative/ complementary medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of the elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary care unit (CCU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer skills/ literature search	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical appraisal skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose and throat (ENT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence-based medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynaecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital care of family practice patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive care unit (ICU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health/ psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palliative care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy/ counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. b) In your opinion, which of the following courses, if any, should be mandatory within family medicine residency training programs?** Please check the courses you feel should be mandatory and then indicate whether or not you are currently certified in those courses, or plan to be certified before the completion of your residency.

Should be mandatory?	Currently have this certification	Plan to have this certification before completion of residency
<input type="checkbox"/> ACLS (Advanced Cardiac Life Support)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> ATLS (Advanced Trauma Life Support)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> ALSO (Advanced Life Support in Obstetrics)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> PALS (Paediatric Advanced Life Support)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> NALS (Neonatal Advanced Life Support)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> PTLS (Paediatric Trauma Life Support)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

**2.c) Does your residency program provide adequate financial support specifically directed for access to obtaining the courses listed above in question #2b?**  Yes  No  Unsure

**3. Will you feel adequately prepared for the kind of practice you are planning to undertake?**  
 Yes  No  Don't know yet

**B. Learning Environment**

**4.a) Do you feel that your family medicine residency experience has taken place in an open learning environment?**

Strongly agree     Agree     Neutral     Disagree     Strongly disagree

**4.b) Do you feel that your family medicine residency experience has taken place in a supportive learning environment?**

Strongly agree     Agree     Neutral     Disagree     Strongly disagree

**4.c) Do you feel that your family medicine residency experience has taken place in a collegial learning environment?**

Strongly agree      Agree      Neutral      Disagree      Strongly disagree  
                       

**5.a) Do you feel that your specialty experiences have taken place in an open learning environment?**

Strongly agree      Agree      Neutral      Disagree      Strongly disagree  
                       

**5.b) Do you feel that your specialty experiences have taken place in a supportive learning environment?**

Strongly agree      Agree      Neutral      Disagree      Strongly disagree  
                       

**5.c) Do you feel that your specialty experiences have taken place in a collegial learning environment?**

Strongly agree      Agree      Neutral      Disagree      Strongly disagree  
                       

**6. Considering all of the areas in medicine, what led you to select family medicine?**

*Please check ALL that apply.*

- |   |   |
|---|---|
| <b>A</b> ? Intellectual stimulation/challenge         | <b>G</b> ? Earning potential                            |
| <b>B</b> ? Doctor-patient relationship                | <b>H</b> ? Research opportunities                       |
| <b>C</b> ? Workload flexibility and/or predictability | <b>I</b> ? Teaching opportunities                       |
| <b>D</b> ? Influence of a mentor                      | <b>J</b> ? Ability to pursue non-work related interests |
| <b>E</b> ? Influence of my family                     | <b>K</b> ? Availability of training opportunities       |
| <b>F</b> ? Prestige                                   | <b>L</b> ? Other _____                                  |

**7. When did you decide on your current residency field?**

- ? Before medical school
- ? During medical school but prior to clerkship
- ? During clerkship
- ? During residency
- ? Other \_\_\_\_\_

**8. Does your university have a confidential mechanism in place to report incidents of sexual harassment, intimidation or other inappropriate incidents in the learning environment?**

Yes       No       Don't know

**9. a) Have you been harassed or intimidated during your residency?**

Yes       No (skip to Question 10)

**If yes, by whom?**

- Staff person
- Medical senior/supervisor
- Another resident (non-supervisory)
- Other (Please specify): \_\_\_\_\_

**9. b) If yes, when did this occur?**

- during a family medicine experience
- during a specialty experience
- both of the above

**9.c) If yes, please state the frequency:** \_\_\_\_\_times per month      Other (please specify): \_\_\_\_\_

**10. During your residency, has your level of stress been significant enough to cause you to:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Take medical leave from your residency?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Consult a physician for stress-related depression? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Take medication?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**11. Have you encountered negative feedback when you have had to leave a specialty service for your half-day return to the family medicine unit?**

Yes       No

**12. Do you feel that the educational and service components of your program are balanced?**

Strongly agree      Agree      Neutral      Disagree      Strongly disagree  
                       

**C. Future Practice/ Work Setting Profile**

**13. Over the next 2-3 years, once you complete your family medicine residency training, do you plan to:**

**a) Practice as a family physician (general practitioner)?**  Yes  No  Don't know yet

**b) Practice as a locum tenens?**  Yes  No  Don't know yet

**c) Buy/ set up your own practice?**  Yes  No  Don't know yet

**d) Practice in a hospital setting?**  Yes  No  Don't know yet

**e) Practice within the same province in which you are currently training?**

Yes  No  Don't know yet

**f) Practice in another province or territory in Canada?**

Yes  No  Don't know yet    *If yes, please specify province or territory:* \_\_\_\_\_

**g) Leave Canada to practise in another country?**  Yes  No  Don't know yet

**h) Specialize within an area of family medicine?**

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Yes  No  Don't know yet *If yes, please specify:* \_\_\_\_\_

**i) Take a temporary leave of absence?**  Yes  No  Don't know yet

**j) i) Continue your residency by undertaking a fellowship position?**

Yes  No  Don't know yet

**j)ii) Continue your residency by undertaking a third year training position?**

Yes  No  Don't know yet

**If Yes**, please indicate which of the following third year training post programs you have applied to/ been accepted to:

	Applied	Accepted
Anaesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Care of the elderly	<input type="checkbox"/>	<input type="checkbox"/>
Emergency medicine	<input type="checkbox"/>	<input type="checkbox"/>
Palliative care	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify) _____		

**k) Change disciplines/ retrain within the medical field?**

Yes  No  Don't know yet *If yes, please specify field:* \_\_\_\_\_

**l) Seek an administrative (non patient care) position?**  Yes  No  Don't know yet

**m) How do you intend to organize your practice setting?**

- Solo practice
- Group practice
- Other \_\_\_\_\_
- Don't know yet
- N/A – Do not intend to set up a practice

**n) Which of the following types of health care providers do you plan to collaborate with in providing patient care? Please check ALL that apply.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Family physicians           | <input type="checkbox"/> Psychologists           | <input type="checkbox"/> Technicians/ technologists            |
| <input type="checkbox"/> Specialist physicians       | <input type="checkbox"/> Occupational therapists | <input type="checkbox"/> Midwives                              |
| <input type="checkbox"/> Nurse practitioners         | <input type="checkbox"/> Physiotherapists        | <input type="checkbox"/> Other _____                           |
| <input type="checkbox"/> Nurses (e.g., RN, LPN, RPN) | <input type="checkbox"/> Social workers          | <input type="checkbox"/> N/A – Don't intend to do patient care |
| <input type="checkbox"/> Dieticians/ nutritionists   | <input type="checkbox"/> Pharmacists             | <input type="checkbox"/> Don't know yet                        |

**o) Are you being actively recruited for a practice location?**  Yes  No

- If yes, by whom?
- USA
  - Other province or territory within Canada
  - Other community within the province
  - Your own community
  - Canadian Forces Health Services
  - Other \_\_\_\_\_

**D. Future Practice/ Work Profile**

**14. Please describe the population PRIMARILY served by the practice you intend to undertake after completion of residency. Please check ONLY ONE.**

- A ? Inner city
- B ? Urban/ Suburban
- C ? Small town
- D ? Rural
- E ? Geographically isolated/ Remote
- F ? Other \_\_\_\_\_
- G ? Don't know yet
- H ? I plan to do locum tenens
- I ? I don't intend to be involved in patient care

**15.a) Which of the following procedures are you planning to perform as part of your practice? Please check as many categories as applicable. Please indicate if you feel you have had adequate training during your residency to perform each procedure.**

	<b>I Plan To Provide</b>	<b>I Have Adequate Training</b>
Audiometry	<input type="checkbox"/>	<input type="checkbox"/>
Refraction	<input type="checkbox"/>	<input type="checkbox"/>
ECG interpretation	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary function testing	<input type="checkbox"/>	<input type="checkbox"/>
Pap smears	<input type="checkbox"/>	<input type="checkbox"/>
IUD insertion	<input type="checkbox"/>	<input type="checkbox"/>
Endometrial aspiration	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar puncture	<input type="checkbox"/>	<input type="checkbox"/>
Casting/ splinting	<input type="checkbox"/>	<input type="checkbox"/>
Aspiration/ injection of joints	<input type="checkbox"/>	<input type="checkbox"/>
Incising & draining abscesses	<input type="checkbox"/>	<input type="checkbox"/>
Anoscopy	<input type="checkbox"/>	<input type="checkbox"/>
Needle aspiration (for diagnosis/ biopsy)	<input type="checkbox"/>	<input type="checkbox"/>
Removal of superficial skin lesions (e.g. nevi, keratoses, cysts)	<input type="checkbox"/>	<input type="checkbox"/>
Cryotherapy of superficial skin lesions (e.g. warts, nevi, lentigo)	<input type="checkbox"/>	<input type="checkbox"/>
Skin biopsy	<input type="checkbox"/>	<input type="checkbox"/>
Suturing	<input type="checkbox"/>	<input type="checkbox"/>
Toenail surgery	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>
D&C aspiration	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrical deliveries	<input type="checkbox"/>	<input type="checkbox"/>
Newborn care	<input type="checkbox"/>	<input type="checkbox"/>

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**15.b) Please indicate ALL areas of professional activity that you intend to include as part of your practice and if you think that certain areas will be of special interest to you. Please note: you do not have to be certified in the area of professional activity to include it in your profile.**

Area of Professional Activity		This will be part of my practice	Area of special interest to me
Addiction medicine	593	?	?
Administration	523	?	?
Alternative/ complementary medicine	599	?	?
Adolescent medicine	625	?	?
Anaesthesia	101	?	?
Cancer care/ oncology	132	?	?
Cardiology	103	?	?
Chronic disease management	699	?	?
Community medicine/ public health	107	?	?
Dermatology/ cosmetic medicine	112	?	?
Emergency medicine	115	?	?
Family practice/ general practice/ primary care	587	?	?
Geriatric medicine/ care of the elderly	121	?	?
Gynecology	308	?	?
Homecare	543	?	?
Hospitalist care	545	?	?
Infectious diseases	125	?	?
International medicine	589	?	?
Legal/ medico-legal consultations	555	?	?
Nutrition	541	?	?
Obstetrics	307	?	?
Occupational/ industrial medicine	139	?	?
Pain management	521	?	?
Palliative care	427	?	?
Pediatrics	141	?	?
Preventive medicine	697	?	?
Psychiatry	167	?	?
Psychotherapy/ counseling	598	?	?
Research	510	?	?
Sports medicine	615	?	?
Surgery	304	?	?
Surgical assisting	306	?	?
Teaching	695	?	?
Travel/ tropical medicine	591	?	?
Women's health care	565	?	?
Other _____	821	?	?
Other _____	822	?	?

16. Do you have a PDA (personal digital assistant/ wireless device)?     Yes     No

**E. Time Allocation**

17. Please indicate in which of the following areas you intend to spend time or participate upon completion of your residency training. *Please check ALL that apply.*

- |  |                          |
|--|--------------------------|
| i) <b>Direct patient care without a teaching component</b> , regardless of setting   | <input type="checkbox"/> |
| ii) <b>Direct patient care with a teaching component</b> , regardless of setting   | <input type="checkbox"/> |
| iii) <b>Teaching/ Education</b> without direct patient care (contact with students/residents, preparation, marking, evaluations, etc.) | <input type="checkbox"/> |
| iv) <b>Indirect patient care</b> (charting, reports, phone calls, meeting patients' family, etc.)                                      | <input type="checkbox"/> |
| v) <b>Health facility committees</b>   | <input type="checkbox"/> |
| vi) <b>Managing your practice</b> (staff, facility, equipment, etc.)   | <input type="checkbox"/> |
| vii) <b>Research</b> (including management of research and publications)   | <input type="checkbox"/> |
| viii) <b>Administration</b> (i.e. management of university program, chief of staff, department head, Ministry of Health, etc.)         | <input type="checkbox"/> |
| ix) <b>Continuing medical education/ professional development</b> (courses, reading, videos, tapes, seminars, etc.)                    | <input type="checkbox"/> |
| x) <b>Other</b> (participation in professional or specialty organizations, medico-legal activities, etc.)                              | <input type="checkbox"/> |



**23.a) At which university are you currently doing your residency medical training?**

- ? University of British Columbia
- ? University of Calgary
- ? University of Alberta
- ? University of Saskatchewan
- ? University of Manitoba
- ? University of Western Ontario
- ? McMaster University
- ? University of Toronto
- ? University of Ottawa
- ? Queen's University
- ? Université de Sherbrooke
- ? Université de Montréal
- ? McGill University
- ? Université Laval
- ? Dalhousie University
- ? Memorial University

**23.b) Please indicate the site of your residency training program.**

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**24. Are you presently enrolled in a 'return of service' program, that is, a program where you have committed yourself to certain practice restrictions [location, specialty, employer, military service, armed forces, etc.] in return for financial compensation during medical school or residency?**

? Yes ? No

**25. Please indicate the amount of debt you had and/or expect to have at various times in your medical education, as indicated below. Please separate these into 1) debt directly related to being in a medical residency program (tuition, books, accommodations, etc.), and 2) other debt (personal, mortgage, car loan, etc.)**

**a) Debt upon entering your medical residency training**

**Debt directly related to being in a medical residency program**

- ☒ no debt
- ☒ less than \$1,000
- ☒ \$1,001 to \$5,000
- ☒ \$5,001 to \$10,000
- ☒ \$10,001 to \$20,000
- ☒ \$20,001 to \$40,000
- ☒ \$40,001 to \$60,000
- ☒ \$60,001 to \$80,000
- ☒ \$80,001 to \$100,000
- ☒ \$100,001 to \$120,000
- ☒ \$120,001 to \$140,000
- ☒ \$140,001 to \$160,000

**Other Debt**

- ☒ no debt
- ☒ less than \$1,000
- ☒ \$1,001 to \$5,000
- ☒ \$5,001 to \$10,000
- ☒ \$10,001 to \$20,000
- ☒ \$20,001 to \$40,000
- ☒ \$40,001 to \$60,000
- ☒ \$60,001 to \$80,000
- ☒ \$80,001 to \$100,000
- ☒ \$100,001 to \$120,000
- ☒ \$120,001 to \$140,000
- ☒ \$140,001 to \$160,000



**28. Marital status.** *Please check ONE only.*

- Single
- Separated, divorced or widowed
- Married / Living with partner

Is your spouse/ partner a: ? Physician      ? Other health care provider      ? Neither

**29. Do you have children or other dependents for whom you personally provide care/ supervision?**

- No
- Yes      If yes, do you have major responsibility for the care of these individuals?  
? Yes              ? No

If these are children, what is the age of the youngest? \_\_\_\_\_ years old

**30. Which of the following describe your family members? If your parents or siblings are retired or deceased, please provide their main occupation while working.**

*Please check ALL that apply.*

	Father	Mother	Sibling(s)
Medical doctor	?	?	?
Nurse	?	?	?
Pharmacist	?	?	?
Other healthcare professional	?	?	?

**31. Select the ONE statement which best describes the environment in which you grew up prior to university.**

- ? Exclusively/ predominantly rural
- ? Exclusively/ predominantly small town
- ? Exclusively/ predominantly urban
- ? Mixture of environments

**32. In which province(s) or territories did you grow up prior to going to university?**

*Indicate ALL that apply.*

BC   AB   SK   MB   ON   QC   NB   NS   PE   NL   NT   YT   NU   Outside of  
Canada

**33. Please enter the first three digits of the postal code where you lived in your final year of high school. If you lived at a boarding school, please enter the postal code of where your family lived during that year. If you did not live in Canada, please indicate the country where you lived.**

If in Canada, first three digits of postal code: \_\_\_\_ \_\_\_\_ \_\_\_\_

If not in Canada, type in the country: \_\_\_\_\_

**34. What is your ethnic/ cultural background?** *Please check ALL that apply.*

- ? White
- ? Aboriginal (e.g., status, non-status, Métis, Inuit)
- ? Chinese
- ? South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- ? Black
- ? Filipino
- ? Latin American
- ? Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- ? Arab
- ? West Asian (e.g., Afghan, Iranian, etc.)
- ? Japanese
- ? Korean
- ? Other \_\_\_\_\_
- ? I prefer not to provide this information

**35. Please indicate the languages that you could comfortably speak with your future patients.**

- ? English
- ? French
- ? Other(s) \_\_\_\_\_

**36. Were you born in Canada?**

- ? Yes
- ? No. Please indicate your status in Canada.
  - ? Canadian citizen
  - ? Permanent resident (landed immigrant)
  - ? Other \_\_\_\_\_

**37. Your year of birth:**     **19**   —   —

**38. Sex:**            male ?        female ?

**39. Comments**

**Please be assured that your response to this survey is anonymous, and that all individual information will be held in the strictest confidence. Analysis and publication of results will be at the aggregate level only.**

Thank you for your time and cooperation.