# 

# Position Request / Candidate Review

# Impact Summary Form

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Please retain a copy of this form when you submit for a position request so that it can be used when submitting the candidate information.** | | | **PART A**  **POSITION REQUEST INFORMATION**  *(Complete PART A when submitting a request for a position)* | **PART B**  **CANDIDATE REVIEW INFORMATION**  *(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)* | | | | | | |
| **DEMOGRAPHIC INFORMATION** | | | | | |
| **EXISTING POSITION NUMBER:** | | | | | |
| **Anticipated Start Date** |  | | **Anticipated Start Date** |  | |
| **Department** |  | | **Department** |  | |
| **Division** |  | | **Division** |  | |
| **Program (if applicable)** |  | | **Program (if applicable)** |  | |
| **Primary Hospital** |  | | **Primary Hospital** |  | |
| **Primary Site** |  | | **Primary Site** |  | |
| **Full or Partial FTE**  **(1.0 / 0.75 / 0.50)** |  | | **Full or Partial FTE**  **(1.0 / 0.75 / 0.50)** |  | |
|  |  | | **Candidate Name** |  | |
|  |  | | **Name of Physician Leaving (if applicable)** |  | |
|  |  | | **Departure Date of Physician Leaving**  **(if applicable)** |  | |
|  |  | | **Candidate Leadership Title**  **(If applicable ie. Chair/Chief)** |  | |
| **PART A**  **POSITION REQUEST INFORMATION**  (Complete PART A when submitting a request for a position) | | | **PART B**  **CANDIDATE REVIEW INFORMATION**  **(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)** | | |
| **RATIONALE FOR SUPPORT** | | | | | |
| Please provide an **IN-DEPTH** statement including clinical, academic & research information in support of this request. Outline how this position request is required to meet an ongoing quality improvement initiative. **If the position is “Mission Critical” please provide a brief statement to support.** | | | Please reaffirm the original rationale that was submitted with the initial position request in PART A to ensure it is updated for the candidate review process. | | |
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| **PROXY INFORMATION** | | | | | |
| Please provide the name of a physician whose practice is similar in terms of patient volumes, resource usage, etc. If this is a replacement position, the appropriate proxy may or may not be the departing physician. If there is a difference in resource impact, please specify in greater detail under the Rationale field. | | | | | |
| **Proxy Name:** | | | **Proxy Name:** | | |
| **Does the position workload expect to mirror this proxy’s workload? Yes No**    If no, please explain: | | | **Does the position workload expect to mirror this proxy’s workload? Yes No**  If no, please explain. If the candidate is requesting new special equipment, technology, or equipment that will result in incremental costs in your own or another department, please explain. | | |
| **CLINICAL RESOURCE INFORMATION**  Please indicate below the room number or N/A if not applicable | | | | | |
| **Physician Office Room Number** | |  | **Physician Office Room Number** | |  |
| **Existing Secretary Name** | |  | **Proposed Secretary** | | **Existing**  **New Hire** |
| **Secretary Office Room Number** | |  | **Secretary Office Room Number** | |  |
| **OR Hours / Week** | |  | **OR Hours / Week** | |  |
| **Avg Number of Inpatient (Beds)** | |  | **Avg Number of Inpatient (Beds)** | |  |
| **Outpatient Clinic:** | |  | **Outpatient Clinic:** | |  |
| **Clinic Hours / Week** | |  | **Clinic Hours / Week** | |  |
| **PART A**  **POSITION REQUEST INFORMATION**  (Complete PART A when submitting a request for a position) | | | **PART B**  **CANDIDATE REVIEW INFORMATION**  **(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)** | | |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Site** | **MON** | | **TUES** | | **WED** | | **THURS** | | **FRI** | | | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | | **UH** |  |  |  |  |  |  |  |  |  |  | | **VH** |  |  |  |  |  |  |  |  |  |  | | **SJH** |  |  |  |  |  |  |  |  |  |  |   **Clinic Schedule:** | | | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Site** | **MON** | | **TUES** | | **WED** | | **THURS** | | **FRI** | | | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | | **UH** |  |  |  |  |  |  |  |  |  |  | | **VH** |  |  |  |  |  |  |  |  |  |  | | **SJH** |  |  |  |  |  |  |  |  |  |  |   **Clinic Schedule:** | | |
| **REQUEST FOR A NEW POSITION – PRIORITIZATION CRITERIA**  **(if applicable and known)** | | | | | |
| **Position Number for a NEW position will be assigned by Medical Affairs:**  **Please use the rationale section that follows to outline the evidence to support the following 4 criteria to prioritize the review of the NEW position. Check off each criteria that applies (if applicable):**  **1. Identified by the Department leader as “Mission Critical” which are positions that severely impact a service’s ability to sustain current level of service (clinical or academic) if not recruited , or addresses a pressing unmet clinical or academic need;**  **2. Addresses institutional priorities of Access, Infection Control or Research Capacity;**  **3. Has identified resources in place to support the new position (Office, Clinic, OR, Diagnostics – Imaging & Labs, Health Disciplines, Research and University commitments);**  **4. The anticipated known impact on diagnostic services can be accommodated as follows:**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **MODALITY** | **VOLUME** | | | | **Actual Volumes of the Proxy** | **COMMENTS** | | **<50** | **50-100** | **>100** | **N/A** | | **X-ray/Fluoroscopy** |  |  |  |  |  |  | | **Ultrasound** |  |  |  |  |  |  | | **CT** |  |  |  |  |  |  | | **MRI** |  |  |  |  |  |  | | **Angio-Interventional** |  |  |  |  |  |  | | **Mammography** |  |  |  |  |  |  | | **Radioisotope (Nuclear Medicine)** |  |  |  |  |  |  | | **Other (please explain)** |  |  |  |  |  |  | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **The impact on the following health disciplines is identified as follows:**   |  |  |  | | --- | --- | --- | | **Health Discipline:** | **Impact:** |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Yes** | **No** | **If you answered YES – Please provide an estimated number of**  **consult hours per week of the additional services required:** |  | | **Audiology** |  |  |  |  | | **Clinical Dietitians** |  |  |  |  | | **Occupational Therapy** |  |  |  |  | | **Physiotherapy** |  |  |  |  | | **Psychology** |  |  |  |  | | **Social Work** |  |  |  |  | | **Speech Language Pathology** |  |  |  |  | | **Other (Please explain)** |  |  |  |  | | | | |
| **The impact on pharmacy services is identified as follows:** | | | |
| **The impact on laboratory services is identified as follows:** | | | |
| |  |  | | --- | --- | | **PART A**  **POSITION REQUEST INFORMATION**  *(Complete PART A when submitting a request for a position)* | **PART B**  **CANDIDATE REVIEW INFORMATION**  *(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)* | | | | |
| **RESEARCH RESOURCE INFORMATION**  Please indicate below the room number or N/A if not applicable. If research is a part of the candidate’s practice profile, please complete the Research Impact Confirmation Form available from Medical Affairs | | | |
| **Dry Lab** |  | **Dry Lab** |  |
| **Wet Lab** |  | **Wet Lab** |  |
| **Clinical Trials** |  | **Clinical Trials** |  |
| **Clinical Research Space** |  | **Clinical Research Space** |  |
| **Other: i.e. Nurse Practitioner / Fellow Office / Research Asst.** |  | **Other: i.e. Nurse Practitioner / Fellow Office / Research Asst.** |  |
| **Are you able to meet all of the research space requirements of this position within your program’s existing research space?** |  | **Are you able to meet all of the research space requirements of this position within your program’s existing research space?** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CAPITAL COSTS (EQUIPMENT, ETC)**  Please provide a description of the capital funding required | | | |
| **If the position is a replacement, are Incremental costs anticipated? Please explain below:**  **If the position is a new position, will the workload be redistributed or are incremental costs anticipated? Please explain below:** | | **Describe the capital funding required to support the candidate and indicate Amount ($) anticipated.** | |
| |  |  | | --- | --- | | **PART A**  **POSITION REQUEST INFORMATION**  *(Complete PART A when submitting a request for a position)* | **PART B**  **CANDIDATE REVIEW INFORMATION**  *(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)* | | | | |
| **ACADEMIC ROLE CATEGORY POSITION PROFILE**  Please indicate the percentage of time allocated for each category (must add up to 100%): | | | |
| **Clinician Teacher**  **Clinician Researcher**  **Clinician Educator**  **Clinician Scientist**  **Clinician Administrator** | | **Clinician Teacher**  **Clinician Researcher**  **Clinician Educator**  **Clinician Scientist**  **Clinician Administrator**  If the category selected is a Clinician Researcher, Educator or Scientist, does the candidate meet the specific requirements of that  category: Yes No | |
| **Clinical Service** |  | **Clinical Service** |  |
| **Teaching** |  | **Teaching** |  |
| **Research** |  | **Research** |  |
| **Administration** |  | **Administration** |  |
| **Health Care Leadership/Role Model/General Contributions** |  | **Health Care Leadership/Role Model/General Contributions** |  |

|  |  |
| --- | --- |
| AFP INFORMATIONPlease indicate Yes, No, or N/A – Not applicable | |
| Is the position replacing a physician who was/is a Phase 3 participant? | Will the candidate be eligible for Phase 3 AFP funding? |

**DECLARATION**

* The department has consulted with the appropriate university, hospital and research representatives and verified that the above-mentioned resource information is correct and that the position profile accurately reflects the planned activities

of the position requested.

* There is no apparent or potential conflict of interest with this candidate and any misrepresentation of information on this form may be grounds for denial of appointment.
* The interview of this candidate included multiple individuals involved in the review and decision process and retention of analysis documentation is available for review.

POSITION REVIEW - PART A

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Chair / Chief

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

CANDIDATE REVIEW - PART B

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Department Chair / Chief

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Please send this form to Medical Affairs  
[medical.affairs@londonhospitals.ca](mailto:medical.affairs@londonhospitals.ca)