## Delta Doctors Program

## Physician Compliance Closing Survey

**Note: Responses to the questions on this survey are strictly confidential. Only designated staff with the Delta Regional Authority will view the responses to the following questions.**

Date: ______________________________

Name: (print or type) ______________________________________________________

Years Served: ______________ Employment Start Date:________________

Address: Home:________________________________ Office:_____________________________

Street Street

________________________________ _____________________________

City/State/Zip City/State/Zip

________________________________ _____________________________

Home Phone Work Phone

Physician's E-mail Address: ___________________________________________________________________

Name of Employer: ___________________________________________________________________________

Address: ___________________________________________________________________________

Street/Location City/State/Zip County

Type of Medical Practice: _____________________________________________________________________

(Example: General Practice, Family Medicine, Pediatrics, etc.)

I hereby certify that I, the undersigned, provided direct patient care for the above listed employer for 40 hours per week, or 160 hours per month, at a worksite(s) located within a HPSA or MUA. I further attest that the information above is truthful and accurate.

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent facts, per requirements of 18 USC 1001 (Title 18, U.S. Code, Part 1, Chapter 47, Section 1001). I further acknowledge that I have not evaded or suppressed any information contained in this document or in any of the supporting materials.

**Physician's Signature:** ___________________________________________________________

**Date:** ___________________________________________________________

**Please answer the following questions:**

1. Rate your overall experience with the Delta Doctors program:

   Excellent Good Average Poor

2. Please list any suggestions you may have to improve the experience of the program?

3. Please list any suggestions you have that would have improved your work experience?

4. After your contracted term is complete, do you plan to continue working at the facility?

5. If not, where do you plan to locate and work next?

6. Would you to continue to practice medicine? If so, what type of medicine would you practice?

7. Please list the reasons why you are leaving your current location.

8. Please list the reasons that would remain at your current location. (higher salary, becoming a partner in the facility, better community experience, etc.)

Please use the space below to make any positive statement or comment on any problem or concern that you have in regard to your overall experience with the Delta Doctors program:

**Please Return Form to:**

Delta Regional Authority
Attention: Delta Doctors Program
236 Sharkey Avenue, Suite 400
Clarksdale, MS 38614