

DC PRIMCARE  
**Primary Care Practice-Based Research Network**

**MEMBERSHIP ENROLLMENT FORM**

Thank you for your enthusiastic participation in our education programs at the Howard University College of Medicine Department of Community and Family Medicine. We are deeply appreciative of your efforts. In continuing our quest to improve primary care for the underserved, we are interested in extending our relationship with you, the primary care physicians in the Washington DC Metropolitan Area. We wish to collaborate with you to build a Practice-Based Research Network (PBRN) to address the common issues in your practice.

1. Are you interested in becoming a registered member of the DC PrimCaRe PBRN? \_\_\_ Yes \_\_\_ No

Name \_\_\_\_\_ Degree(s) \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Extension \_\_\_\_\_

Fax (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**Office Contact Name** \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Extension \_\_\_\_\_

2. How many patients do you see in your office per month? \_\_\_\_\_

3. What percentage % of your patients are:

\_\_\_\_\_ 0 years – 12 years

\_\_\_\_\_ 13 years – 18 years

\_\_\_\_\_ 19 years – 40 years

\_\_\_\_\_ 40 years – 64 years

\_\_\_\_\_ 65 years of greater

\_\_\_\_\_ Black/African

\_\_\_\_\_ Hispanic/Latino

\_\_\_\_\_ Asian American

\_\_\_\_\_ American Indian

\_\_\_\_\_ White

\_\_\_\_\_ Other: \_\_\_\_\_

3. Do you accept Medicaid? \_\_\_ Yes \_\_\_ No

3a. If yes, what percentage of your patients are covered by: \_\_\_\_\_ Medicaid

\_\_\_\_\_ DC Healthcare

4. Number of years in practice: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

5. How many physicians are in your practice? \_\_\_

6. How would you describe your practice? \_\_\_ Solo Practice \_\_\_ Group Practice \_\_\_ Multi-specialty Group

7. Please indicate your specialty:

Preventive Medicine

Family Practice

Pediatrics

Internal Medicine

Other: \_\_\_\_\_

**Demographic Information**

8. Gender \_\_\_ Male \_\_\_ Female

9. Age: \_\_\_\_\_

10. Race/Ethnicity: \_\_\_\_\_

(Please continue to complete survey on back. Thank you.)

**PHYSICIAN INTEREST SURVEY**

- 1. What is your level of interest at present?
  - I would like to receive information only at present
  - I am willing to consider participating in developed research project
  - I am interested in developing a new research proposal
  
- 2. Do you have research experience?
  - No previous experience
  - Collected data only
  - Secured grant funding
  - Conducted research through funding not personally secured
  - Conducted unfunded research

**Research Training**

Professionals with little or no research experience can still take part in the DC PrimCaRe research activities as research training and guidance can be provided. You may wish to indicate your interest or experience in the following:

	Experience	Interest
3. Developing research questions for research	_____	_____
4. Designing a research study	_____	_____
5. Analyzing and interpreting results	_____	_____
6. Applying for funding	_____	_____
7. Writing up results for publication	_____	_____

8. Please list your research interest:

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**Thank you for your interest in the DC PrimCaRe PBRN!  
You will receive a New Member package by mail.**

**Send to:**

**Finie Hunter, DC PrimCaRe Coordinator**  
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