Board of Certification in Urgent Care Medicine

Urgent Care Practice Hours and Single-Facility Verification Letter

Applicant Name: _____ Date: _____

Name of Urgent Care facility: _____

Address of Urgent Care facility: _____

_____

Facility phone no.: _____

Days and hours of operation _____

Name of director or lead administrator of facility: _____

Phone/contact number for administrator: _____

Is this urgent care facility accredited or certified ? ☐ Yes ☐ No If so, by whom? _____

Approximately what percentage of the services provided in this facility are for episodic care for patients with acutely-arising, non-life-threatening conditions? _____%

Approximately what percentage of the services provided in this facility are for scheduled follow-up visits and other non-acute services (physical exams, testing, counseling)? _____%

What other medical or health-care services are provided in this clinic facility?: _____

_____

What lab testing can be performed within this facility? *(Please circle all that apply)*

Basic urinalysis Pregnancy testing Rapid strep CBC Blood chemistries

Do you have the ability to perform and interpret on-site labs at this facility? ☐ Yes ☐ No

Do you have the ability to perform and interpret plain x-rays at this facility? ☐ Yes ☐ No

Do you have the ability to perform and interpret EKG's at this facility? ☐ Yes ☐ No

How many hours have you worked at this facility in the last 12 months? _____

What has been your overall time period of practice at this facility? _____ to _____
month/year *month/year*

How many hours have you worked at this facility overall during this time period? _____

Please also include a year-by-year enumeration of work-hours, and, if applicable, teaching hours, on clinic/facility/institution letterhead, signed by applicant and by medical director, lead administrator, or chairman.

By signing below, both the applicant and administrator assert that the above information is true and complete.

Applicant Signature _____ Date: _____

Administrator Signature: _____ Date: _____