

[Full Name, MD]

[City, State] | [email@example.com] | [Phone Number] | [LinkedIn Profile or Professional Website]

PROFESSIONAL SUMMARY

[Board-certified Family Medicine Doctor] with [X+] years of experience providing comprehensive, patient-centered primary care to diverse populations across outpatient and inpatient settings. Skilled in chronic disease management, preventive medicine, and acute care, with a strong focus on continuity of care and evidence-based practice. Adept at collaborating in multidisciplinary teams, optimizing clinic workflows, and leveraging [EMR/EHR system, e.g., Epic] to enhance quality and safety. Committed to [holistic, culturally competent care] and patient education to improve long-term health outcomes.

EXPERIENCE

[Family Medicine Physician] | [Community Health Clinic Name]

[Month Year] – Present | [City, State]

- Provide full-spectrum primary care to an average panel of [X,XXX] patients, including preventive care, chronic disease management (e.g., [diabetes, hypertension, COPD]), and acute visits, consistently maintaining patient satisfaction scores above [X%].
- Implemented evidence-based care pathways for [chronic conditions, e.g., type 2 diabetes and hypertension], resulting in a [X%] improvement in [A1c control/blood pressure control] rates over [12] months as tracked in [clinic quality dashboard or QI registry].
- Collaborate with an interdisciplinary team including [nurses, behavioral health specialists, pharmacists, and social workers] to coordinate care, reduce avoidable ED visits by [X%], and support patients with complex medical and psychosocial needs.

[Family Medicine Resident Physician] | [Teaching Hospital / Academic Medical Center]

[Month Year] – [Month Year] | [City, State]

- Completed [3]-year ACGME-accredited Family Medicine residency with rotations in [inpatient medicine, pediatrics, OB/GYN, geriatrics, emergency medicine, behavioral health, and community medicine], managing diverse patient populations across the lifespan.
- Led a quality improvement project focused on [e.g., preventive screening rates, immunization adherence, or transitions of care], achieving a [X%] increase in [target metric] and presenting results at [institutional QI day or regional conference].
- Precepted and mentored [medical students/PA students] in outpatient clinics, modeling patient-centered interviewing, shared decision-making, and appropriate use of clinical guidelines such as [USPSTF, ADA, ACC/AHA].

EDUCATION

[Doctor of Medicine (MD)] | [Medical School Name]

[Month Year] – [Month Year] | [City, State]

- Relevant activities: [Family Medicine Interest Group, Primary Care Track, Student-Run Free Clinic, Global Health Elective].

[Bachelor of Science in Biology] | [Undergraduate Institution Name]

[Month Year] – [Month Year] | [City, State]

- Honors: [e.g., Magna Cum Laude, Dean's List, Honors Program].

SKILLS

Clinical: [Chronic disease management (diabetes, hypertension, COPD, CHF)] · [Preventive care & wellness exams] · [Women's health & contraception counseling] · [Pediatric and adolescent care] · [Geriatric care & polypharmacy review] · [Minor procedures (e.g., joint injections, skin biopsies, I&D, suturing)]

Technical: [EMR/EHR systems (e.g., Epic, Cerner, eClinicalWorks)] · [e-Prescribing] · [Telemedicine platforms] · [Clinical decision support tools] · [Population health dashboards]

Quality & Safety: [Evidence-based practice] · [Quality improvement methodologies (PDSA, root cause analysis)] · [Care coordination] · [Panel management] · [Risk stratification]

Communication & Leadership: [Patient and family education] · [Motivational interviewing] · [Interdisciplinary team collaboration] · [Precepting and teaching learners] · [Culturally competent care]

Languages: [English (Native/Fluent)] · [Spanish/Other language (Proficient/Conversational)].

PROJECTS & PROFESSIONAL ACTIVITIES

[Chronic Disease Management Quality Improvement Initiative] | [Clinic or Residency Program]

[Month Year] – [Month Year]

- Analyzed clinic panel data to identify gaps in [A1c control, blood pressure control, or statin use], developed an outreach and follow-up protocol, and collaborated with nursing staff to implement standing orders and reminder systems.
- Achieved a [X%] increase in patients meeting [defined control targets] within [X] months, documented process changes, and created a standardized workflow adopted by the broader care team.

[Telehealth Implementation & Optimization Project] | [Primary Care Practice or Health System]

[Month Year] – [Month Year]

- Participated in the rollout and refinement of [telemedicine platform name] for primary care visits, helping design visit templates, patient education materials, and clinical triage guidelines for virtual vs. in-person care.
- Contributed to a [X%] increase in successful virtual visit completion rates and improved access for patients with [transportation, childcare, or mobility] barriers, as measured by appointment utilization data.