

## FACILITY INFORMATION (Please Print)

Facility Name: \_\_\_\_\_ Medical Director: \_\_\_\_\_

## APPLICANT INFORMATION (Please Print)

CPSA Registration Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ Given/First Names: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Degree & Specialty: \_\_\_\_\_

Current AHS Privileges:  Yes  No Specify: \_\_\_\_\_

## ADDITIONAL DOCUMENTS REQUIRED WITH THIS APPLICATION

- If applicant has current privileges with Alberta Health Services (AHS), attach a copy of a **recent Reference Letter** from the applicable AHS Zone Medical Affairs Office confirming those privileges. Examples of acceptable letters include: Appointment Confirmation Letter and a Medical Staff Appointment Memorandum.
- If applicant does NOT have current privileges with Alberta Health Services (AHS), attach a description of **Training and Qualifications and Experience** with the procedure(s) AND **letters from two physicians attesting to the skill and judgment of the applicant to perform such procedures.**
- **Anesthesia only** – If the applicant does hold anesthesia privileges at another NHSF, a full application is not required. Please complete the anesthesia checklist only.
- A completed Procedure Checklist. Select the linked sub-specialty from the list below:

Anesthesia	Assisted Reproductive Technology (ART)	Dermatology	Extended-Stay
General Surgery	Gynecology	Ophthalmology	Orthopedic Surgery
Otolaryngology	Plastic Surgery	Stem Cell Regenerative Therapy - BMAC	
Stem Cell Regenerative Therapy - ADSC		Urology	

Only procedures included on the College's list of [Approved Procedures for Non-Hospital Surgical Facilities](#) will be considered with this application.

## MEDICAL DIRECTOR CHECKLIST

Please include the following with this application form and submit as ONE complete package to the College. **Ensure you retain a copy for your files:**

- ✓ AHS Reference Letter confirming applicant's current privileges OR Description of Training and Qualifications and Experience with procedure(s) along with two professional reference letters
- ✓ If applicable, a copy of current ACLS certification
- ✓ Completed sub-specialty Procedure Checklist

An incomplete application will delay processing. If you have any questions completing this form, please contact our Accreditation Department at 780-969-5002 or 1-800-320-8624 ext. 5002 (in Alberta).

**Privacy Notice:** The College of Physicians & Surgeons of Alberta collects, uses and/or discloses your personal information with your consent or as authorized or required by law and in accordance with our Privacy Statement. We collect and use your personal information in order to support the business of the College, specifically protect the public and to guide and regulate our members.

**Applicant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Medical Director Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please return your completed application and required documents (together as one package) to the College of Physicians & Surgeons of Alberta by fax: 780-428-2712 or by mail:  
2700 - 10020 100 ST NW, Edmonton AB T5J 0N3