COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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Appropriate Procedures List

HOME SLEEP APNEA TESTING

Physician name: _____ CPSID: _____

Independent diagnostic facility applying to: _____

Procedures must only be performed in an accredited diagnostic facility.

Please indicate only the procedures you wish to perform at the above-mentioned facility.

- ☐ Home sleep apnea testing (level 3)

I hereby certify that the procedures selected in this application are within the scope of my current practice.

Physician signature: _____ Date: _____

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