COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

T 604-733-7758
TF 1-800-461-3008
F 604-733-3503

300–669 Howe Street
Vancouver BC V6C 0B4
Canada

cpsbc.ca

Appropriate Procedures List

LABORATORY MEDICINE

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.

- ☐ Anatomic pathology
- ☐ Chemistry
- ☐ Cytogenetics
- ☐ Cytology
- ☐ Hematology
- ☐ Microbiology
- ☐ Molecular diagnostics
- ☐ Specimen collection, transportation and management
- ☐ Transfusion medicine
- ☐ All point-of-care testing
- ☐ Immunology
- ☐ Mobile point-of-care testing
- ☐ Mobile specimen collection

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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The personal information collected on this form is permitted under sections 26(c) and (e) of *FIPPA* for the purpose of managing your accreditation.

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