COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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300–669 Howe Street
Vancouver BC V6C 0B4
Canada

cpsbc.ca

Provisional Accreditation Application

DAP LABORATORY MEDICINE

FACILITY INFORMATION

Facility/hospital/health centre name: _____

Health authority (if applicable): _____

Address: _____

City: _____ Postal code: _____

Projected date of facility opening or discipline starting: _____

BUSINESS CONTACT INFORMATION

Applicant name: _____

Title: _____

Phone number: _____ Unique email: _____

MEDICAL DIRECTOR

Name: _____

Phone number: _____ Unique email: _____

Licensure status: _____

Education:

☐ Attached separately

Qualifications and experience:

☐ Attached separately

FACILITY OWNERS (IF INDEPENDENT)

Name	Percent/share

Other comments (if applicable):

OTHER LOCATIONS CURRENTLY ACCREDITED

☐ Not applicable

Facility name	Address

SCOPE OF SERVICES TO BE ACCREDITED

Select all that apply

- ☐ Anatomic pathology
- ☐ Chemistry
- ☐ Cytogenetics
- ☐ Cytology
- ☐ Hematology
- ☐ Microbiology
- ☐ Molecular diagnostics
- ☐ Point of care testing
- ☐ Sample collection
- ☐ Transfusion medicine
- ☐ Other (list): _____

Are multiple services consolidated into one area (core laboratory)? If so, indicate below.

- ☐ Chemistry
- ☐ Hematology
- ☐ Microbiology
- ☐ Transfusion medicine

For each scope of service to be accredited, complete the Scope of Accreditation and PT Enrolment form.

Days and hours of operation

☐ Monday	◯ 24 hours	◯ Other: ____ to ____		☐ Tuesday	◯ 24 hours	◯ Other: ____ to ____	
☐ Wednesday	◯ 24 hours	◯ Other: ____ to ____		☐ Thursday	◯ 24 hours	◯ Other: ____ to ____	
☐ Friday	◯ 24 hours	◯ Other: ____ to ____		☐ Saturday	◯ 24 hours	◯ Other: ____ to ____	
☐ Sunday	◯ 24 hours	◯ Other: ____ to ____					

OTHER LOCATIONS ACCREDITED OR TO BE ACCREDITED BY THE DAP

Does your organization have other locations accredited or to be accredited by the DAP?

◯ Yes ◯ No

DIAGNOSTIC FACILITY (OFF-SITE)

Facility 1

Facility name: _____

Address: _____

City: _____ Postal code: _____

Phone: _____

Facility 2

Facility name: _____

Address: _____

City: _____ Postal code: _____

Phone: _____

Facility 3

Facility name: _____

Address: _____

City: _____ Postal code: _____

Phone: _____

Facility 4

Facility name: _____

Address: _____

City: _____ Postal code: _____

Phone: _____

ADDITIONAL INFORMATION

Other information you wish to add:

Email completed form to laboratorymedicine@cpsbc.ca.

The College of Physicians and Surgeons of BC (CPSBC) collects, uses, discloses, stores, and retains personal information under the legal authority of the *Freedom of Information and Protection of Privacy Act* (*FIPPA*), RSBC 1996, c.165 and the CPSBC Bylaws made under the *Health Professions and Occupations Act* (*HPOA*), SBC 2022, c.43.

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

If you have any questions or concerns about CPSBC privacy practices, please email privacy@cpsbc.ca.