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

NEURODIAGNOSTIC SERVICES

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.

- ☐ Electroencephalography
- ☐ Evoked potentials
- ☐ Electromyography
- ☐ Nerve conduction studies

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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