COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES ACCREDITATION PROGRAM

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Vancouver BC V6C 0B4
Canada

cpsbc.ca

Application to Medical Director for Appointment to a Non-hospital Medical/Surgical Facility

PODIATRIST

FACILITY INFORMATION

Facility name: _____ NHID: _____

Submission date: _____ Requested start date: _____

PERSONAL INFORMATION

First name: _____ Middle name: _____

Last name: _____ Practitioner type: _____

BUSINESS CONTACT INFORMATION

Professional/incorporated name: _____

Address: _____

City: _____ Province: _____

Postal code: _____ Phone number: _____

Email address: _____

HOME CONTACT INFORMATION

Address: _____

City: _____ Province: _____

Postal code: _____ Phone number: _____

Email address: _____

PREFERRED METHOD OF CONTACT

Mailing address: ☐ Business ☐ Home

Email: ☐ Business ☐ Home

Phone: _____

EMERGENCY CONTACT INFORMATION

First name: _____ Last name: _____

Relationship to applicant (optional): _____ Phone number: _____

Notes: _____

BC LICENSURE

Type of licence: _____

Licence status: _____ Name of BC college: _____

Number: _____ Field of licensure: _____

PROFESSIONAL LIABILITY PROTECTION

Insurance provider: ◯ CMPA ◯ MPP ◯ CDSPI ◯ ENCON ◯ Other: _____

Plan/membership number: _____ Code: _____ MSP billing number: _____

Effective date: _____ Expiry date: _____

APPOINTMENT

Medical staff category requested (at non-hospital facility):

◯ Provisional (new medical staff to first year on staff)

◯ Temporary (defined time period and/or specified number of cases) End date: _____

Discipline: _____ Discipline subspecialty: _____

Current and previous restrictions to license or scope of practice (voluntary, self-imposed, imposed):

APPROPRIATE PROCEDURES LIST

An appropriate procedures list indicating only the procedures you are applying to perform at the above facility must be submitted with the application (refer to the BC MQI Provincial Privileging Dictionaries for core procedures in your area of practice.

◯ Appropriate procedures list attached

◯ N/A

CERTIFICATE OF PROFESSIONAL CONDUCT

I have requested for CPSBC to release to the medical director a current certificate of professional conduct.

◯ Consent for certificate of professional conduct sent to cpc@cpsbc.ca

◯ N/A

REFERENCES

Name **two professional referees** with whom you have worked within the last three years. One must be the head of hospital department or division or senior medical administrator of the organization in which you most recently worked or the program director, if you have recently completed postgraduate training.

Applicants requesting privileges/practice activities requiring special skills must include at least one reference specifically addressing recent training and/or experience in these areas.

References must have current knowledge of the individual and their practice. Each referee must complete the Reference for Applicants for Privileges at Non-hospital Medical/Surgical Facility form.

Additional references may be requested.

Chief of staff/senior medical administrator/program director

Name: _____ Organization: _____

Position: _____ Professional relationship: _____

City: _____ Email: _____

Phone number: _____ Extension: _____

Medical colleague

Name: _____ Organization: _____

Position: _____ Professional relationship: _____

City: _____ Email: _____

Phone number: _____ Extension: _____

EDUCATION

Program type: _____ Degree/diploma: _____

Institution name: _____

City: _____ Country: _____

From: _____ To: _____

Program type: _____ Degree/diploma: _____

Institution name: _____

City: _____ Country: _____

From: _____ To: _____

Program type: _____ Degree/diploma: _____

Institution name: _____

City: _____ Country: _____

From: _____ To: _____

TRAINING

Program type: _____ Degree/diploma: _____

Institution name: _____

City: _____ Country: _____

From: _____ To: _____

Program type: _____ Degree/diploma: _____

Institution name: _____

City: _____ Country: _____

From: _____ To: _____

Program type: _____ Degree/diploma: _____

Institution name: _____

City: _____ Country: _____

From: _____ To: _____

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Society: _____ From: _____ To: _____

Society: _____ From: _____ To: _____

Society: _____ From: _____ To: _____

OTHER TRAINING SKILLS/CERTIFICATION

BLS (HCP or equivalent), ACLS, PALS, difficult airway course, laser training, radiation safety training, diplomas in advanced skills, etc.

Online BLS and ACLS certification and recertification courses without a classroom hands-on component led by a certified instructor are not accepted. Please note that BLS and ACLS certification are valid for two years from date of issuance.

Please provide a copy of all training documentation.

Course	Date issued	Attached
BLS (mandatory)	_____	☐
_____	_____	☐
_____	_____	☐

CURRENT REGISTRATIONS/LICENCES IN OTHER JURISDICTIONS

Jurisdiction: _____ Specialty: _____ From: _____ To: _____

Jurisdiction: _____ Specialty: _____ From: _____ To: _____

CURRENT ACADEMIC APPOINTMENTS

Institution name: _____

Department/specialty: _____ Academic rank: _____

Institution name: _____

Department/specialty: _____ Academic rank: _____

COMMITTEE MEMBERSHIP AND LEADERSHIP ROLES

Facility or program: _____

Committee/leadership role: _____ From: _____ To: _____

Facility or program: _____

Committee/leadership role: _____ From: _____ To: _____

MEMBERSHIP(S) ON MEDICAL STAFF IN BRITISH COLUMBIA

Health authority, hospital, facility, or program: _____

City: _____ From: _____ To: _____

Discipline: _____ Medical staff/personnel category: _____

Health authority, hospital, facility, or program: _____

City: _____ From: _____ To: _____

Discipline: _____ Medical staff/personnel category: _____

OTHER RELEVANT EXPERIENCE

Institution name: _____

City: _____ Province/state: _____ Country: _____

From: _____ To: _____

Experience: _____

WORK HISTORY

Hospital/non-hospital/organization: _____

City: _____ Province/state: _____ Country: _____

From: _____ To: _____ Position: _____

Reason for leaving: _____

Hospital/non-hospital/organization: _____

City: _____ Province/state: _____ Country: _____

From: _____ To: _____ Position: _____

Reason for leaving: _____

Hospital/non-hospital/organization: _____

City: _____ Province/state: _____ Country: _____

From: _____ To: _____ Position: _____

Reason for leaving: _____

DECLARATION FOR APPOINTMENT TO THE MEDICAL STAFF

1. Professional liability coverage or protection

I declare that:

◯ I have professional liability protection through the Canadian Medical Protective Association (CMPA) that extends to all areas of my practice.

◯ I have professional liability protection through a policy of professional liability insurance from a BC-licensed company that provides coverage of at least $3,000,000 and extends to all areas of my practice.

2. Have you ever had your health authority, hospital or non-hospital privileges revoked, suspended or restricted in any way, or have you surrendered or altered your privileges as a result of potential revocation, suspension or restriction? ◯ Yes ◯ No

3. Have you ever had any disciplinary actions, complaint investigations, practice reviews, formal reviews, or other proceedings initiated, pending or completed against you by a hospital or non-hospital facility? ◯ Yes ◯ No

4. Have you ever had any disciplinary actions, complaint investigations, practice reviews, formal reviews, or other proceedings initiated, pending or completed against you by the Medical Services Commission or a licensing authority? This does not include the College of Physicians and Surgeons of BC. ◯ Yes ◯ No

5. Have you ever been disciplined or entered into a formal agreement or given a formal undertaking to the Medical Services Commission or a licensing authority, to address a discipline matter, investigation, practice review, formal review or other proceeding? This does not include the College of Physicians and Surgeons of BC. ◯ Yes ◯ No

6. Have you ever had any civil court make a finding against you or have you entered into an out-of-court settlement relevant to your medical practice? ◯ Yes ◯ No

7. Have you ever been charged with a criminal or similar offence? This includes if you have received an absolute or conditional discharge, if the charges were dismissed, stayed, withdrawn, or did not result in a conviction. This also includes charges for which you were granted a pardon. ◯ Yes ◯ No

8. Have you ever been convicted of a criminal or similar offence? ◯ Yes ◯ No

9. Have you ever had a peace bond or restraining order issued against you that is relevant to your medical practice? ◯ Yes ◯ No

If you answered yes to any of the above, please give full details in the space provided below (and on a separate sheet of paper if you require additional space). Answering yes to any of the questions does not necessarily preclude appointment to the medical staff. The non-hospital facility medical director will use this information to assess your ability to deliver appropriate patient care.

APPLICANT ACKNOWLEDGEMENT AND CONSENT

I understand and agree that I have the burden of providing adequate information for the proper evaluation of my professional competence, character, ethics, qualifications, licensure, insurance and other qualifications and for responding to any inquiries about such information to the satisfaction of the non-hospital facility medical director.

I am a registrant in good standing with my professional college.

I agree to:

- abide by the *Code of Ethics and Professionalism* as adopted by my professional college at all times during my appointment to the medical staff.
- maintain and provide proof of professional liability insurance protection appropriate to my professional activities within the non-hospital facility.
- inform the non-hospital facility medical director of any changes that would affect my ability to practice medicine and the type of practice I undertake while a member of the medical staff (e.g. licensure, professional liability insurance coverage, my health, qualifications, immigration status).
- release the non-hospital facility, employees, agents, staff and medical staff from all liabilities and claims for losses sustained in connection with evaluating my application for medical staff membership, except where such losses are caused by their gross negligence or intentional misconduct.

I acknowledge that:

- I have read the College of Physicians and Surgeons of BC Bylaws, the NHMSFAP standards and policies, and the medical staff rules of the non-hospital facility regarding professional conduct and assessment.
- if appointed to the medical staff, I will fulfill my responsibilities as a member of the medical staff, as defined in the CPSBC Bylaws, the NHMSFAP standards and policies, and the medical staff rules of the non-hospital facility.
- any breach of the above agreement, or any misrepresentation or material omission on my part in completing this application may result in the denial, revocation or suspension of my appointment to the medical staff.

I understand that the non-hospital facility and the NHMSFAP will collect, use and disclose personal information about me for the purposes of:

- evaluating my application for medical staff membership.
- administering and maintaining my medical staff membership and relationship with the non-hospital facility including maintaining privileges/practice activities and access to information systems and equipment.
- non-hospital facility and NHMSFAP Committee planning.

I consent to the following:

- the non-hospital facility and NHMSFAP may contact the referees whose names I have provided for the purpose of evaluating my application for appointment/reappointment/employment and privileges/practice activities.
- my personal information will be stored by the non-hospital facility and the NHMSFAP and may be shared with other BC health authorities and their affiliates for the purposes stated above.

APPLICANT AUTHORIZATION

In signing this document:

- I acknowledge I have read and understand the points in the above declaration and acknowledgment.
- I declare that I have requested only those privileges for which by education, training and current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at the non-hospital facility I am applying.
- I declare that the information submitted by me in this application is true to the best of my knowledge.

I hereby apply for appointment to the medical staff of: _____

Applicant signature: _____ Date: _____

MEDICAL DIRECTOR DECLARATION AND RECOMMENDATION FOR APPOINTMENT

In signing this document:

- I acknowledge that I have reviewed this medical staff application for appointment, requested clinical privileges, and supporting documentation.
- I acknowledge that I am responsible for notifying the Non-Hospital Medical and Surgical Facilities Accreditation Program of this medical staff appointment by submitting the Notification of Medical Staff Appointment form.

I hereby:

☐ Appoint this medical staff be granted all privileges as requested on the appropriate procedures list(s)

☐ Recommend that this medical staff be granted privileges with the following conditions/modifications

☐ Do not recommend that this applicant be granted privileges

Privilege condition/modification/explanation:

Medical director signature: _____ Date: _____

NEXT STEPS

For medical directors of accredited facilities:

- Maintain a copy of this form and supporting documents in the medical staff's human resources file
- Notify the NHMSFAP of new staff appointments by submitting the Notification of New Medical Staff Appointment form and appropriate procedures list(s)
- See the CPSBC website for more information

For new facilities applying for accreditation:

- Submit this form and supporting documents to NHMSFAP
- See the CPSBC website for more information

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.