COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES ACCREDITATION PROGRAM

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Appropriate Procedures List
DENTAL

Physician name: _____ CPSID: _____

Facility applying to: _____

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

- ☐ Alveolectomy
- ☐ Caries
- ☐ Dental implants
- ☐ Extractions
- ☐ Minor oral surgery – root resections/dissections
- ☐ Pediatric dental – caries, extractions, excision lesions, restorations
- ☐ Restorations

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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