COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES ACCREDITATION PROGRAM

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Appropriate Procedures List
HAIR TRANSPLANT

Physician name: _____ CPSID: _____

Facility applying to: _____

Please indicate only the procedures you wish to perform at the above-mentioned facility. The facility must be currently approved for a hair transplant program, or the medical directory must submit a Proposal for New/Experimental Procedure form.

Hair transplantation

- ☐ Follicular unit grafting
- ☐ Robotic
- ☐ Other: _____

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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