COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES ACCREDITATION PROGRAM

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Appropriate Procedures List
NEUROSURGERY

Physician name: _____ CPSID: _____

Facility applying to: _____

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

- ☐ Anterior cervical decompression/discectomy with fusion (maximum 2 levels)
- ☐ Lumbar discectomy
- ☐ Laminectomy – cervical (maximum 2 levels)
- ☐ Laminectomy – lumbar (maximum 2 levels)

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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