COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES ACCREDITATION PROGRAM

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Vancouver BC V6C 0B4
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Appropriate Procedures List
SURGICAL ASSIST

Physician name: _____ CPSID: _____

Facility applying to: _____

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

☐ Surgical assist

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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