College of Physicians & Surgeons of Alberta

Vestibular Testing – Private Laboratory
New Facility Application

SECTION 1 - GENERAL FACILITY INFORMATION

Facility Name	
Owner(s)	
Address	
Phone	
Fax	
Email	

Hours of Operation:

What are the routine days and hours of operation?	

SECTION 2 - PERSONNEL

Contact Information for Medical Director

Name		Registration #
Address for correspondence		
Phone		
E-mail		

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Vestibular Laboratory Supervisor/Manager

Name	
Qualifications	
Phone	
E-mail	

Consultant (if applicable)

Name		Registration #
Qualifications		
Phone		
E-mail		

Technical Personnel:

List the number of full time equivalents:	**FTE**	**Please list which healthcare related field the tech(s) has graduated from? This may include, but is not limited to: audiologist, clinical neurophysiologist, EEG technologist, and/or registered nurse.**
Technologists		

* Please submit copies of:
  - HCP CPR

SECTION 3 - TESTING

Vestibular Procedures	Estimated Number Performed Each Month
• Basic ENG:	
o EOG calibration	
o Saccade test	
o Spontaneous and gaze evoked nystagmus	
o Ocular pursuit testing	
o Positional nystagmus	
o Bithermal caloric test	
o Failure of fixation suppression	
• Specialized Procedures:	
o Rotation testing (rotating chair)	
o Posturography	
o Optokinetic nystagmus (OKN)	
o Others	

SECTION 4 - INTERPRETERS

List of Physicians Interpreting Vestibular tests in the Laboratory

Physician Name	Registration #	Specialty (Neurology or Otolaryngology)

SECTION 5 - REQUIRED DOCUMENTATION FOR SUBMISSION

Documentation Required
*Please send **COPIES** of all documentation as these will not be returned.

- Organization structure (e.g. Organization chart)
- Copies of technical staff HCP CPR
- Copy of Policy and Procedure Manual (do not send original)

SECTION 6 - EQUIPMENT

Onsite Equipment & Maintenance – please have the calibration records (as applicable) available for the assessment team on the day of the assessment.

Type of Equipment (which needs to be quality checked and/or calibrated)	Year of Manufacture	Serial No.	Date Acquired	Daily Inspection Documented	Regular Maintenance performed by qualified personnel (Indicate name of staff, contractor or NA)

SECTION 7 - SIGNATURE

I have reviewed and confirm the above facility and assessment information and documentation.

Medical Director/Designate Name (please print): _____

Date: _____

Signature: _____

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Please submit completed form, along with required documentation to the College. All documentation must be returned to the College before an assessment date can be scheduled.

Attn: Chelsey Lockrem
Accreditation Department
College of Physicians & Surgeons of Alberta
2700, 10020 – 100 Street NW
Edmonton, Alberta T5J 0N3
Chelsey.Lockrem@cpsa.ab.ca

Print Form