College of Physicians & Surgeons of Alberta

2700 - 10020 100 Street NW
Edmonton, AB, Canada T5J 0N3

Application Form
Hair Transplantation Approval

Approval for hair transplantation will be granted to physicians who demonstrate sufficient education and experience in the procedures and the operation of a hair transplant practice. Those practices must also demonstrate compliance with infection prevention and control requirements, including the cleaning, disinfection and sterilization of medical equipment.

A. Personal Identification

Name: ______________________________

CPSA Registration #: ______________________________

Mailing Address: ______________________________

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Location of Practice ______________________________

(if different than above): ______________________________

Business Phone No: ______________ Business Fax No: ______________

Type of Practice: Family: ☐

Specialty: ☐ Type: ______________

B. Education and Experience

Please attach supporting documentation.

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C. Infection Prevention & Control Requirements

Has your office been inspected by the College's Infection Prevention & Control Program?

No ❑

Yes ❑ If yes, please indicate clinic name and number, and date of inspection:

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D. Application Fee

☐ I have enclosed a signed cheque in the amount of $200.00 + GST

☐ I have provided my Credit Card information on the attached form and approve the College to charge me $200.00 + GST.

______________________________________ ______________________________

Practitioner's Signature **Date**

Please forward your application to:

Registrar Approvals
College of Physicians & Surgeons of Alberta
2700, 10020 – 100 Street NW
Edmonton AB T5J 0N3

Email: allison.porter@cpsa.ab.ca / Phone: 780-969-4928 / Toll Free: 1-800-320-8624 ext. 4928 / Fax: 780-420-0651

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Credit Card Payment Form

$200.00 + GST application fee for Hair Transplantation application

Full Name: ____

CPSA Registration or CPSA Tracking Number: ____

To pay by VISA, MasterCard or American Express complete and forward the following information to the College of Physicians & Surgeons of Alberta:

- ☐ VISA
- ☐ MasterCard
- ☐ American Express

Card Number: ____

Expiry Date (MM/YY): ____

Cardholder Name (Please Print): ____

Cardholder Signature: ____

Please note that this form and information will be destroyed 60 days following receipt.