College of Physicians & Surgeons of Alberta

Neurophysiology

Application for Registration

Tele - EEG

General Information – Receiving Site

Part A – Facility

Name: _____

Address: _____

_____

Telephone Number: _____ Fax Number: _____

Part B – Personnel

Local Medical Director

Name: _____

Medical Qualifications: _____

Interpreters (All physicians interpreting studies in this facility ***must*** be listed here. Use a duplicate page if there are more than three interpreters.)

1. Name: _____

   Number of Examinations per week: _____

   Do you have College approval to interpret EEGs: Yes ☐ No ☐

2. Name: _____

   Number of Examinations per week: _____

   Do you have College approval to interpret EEGs: Yes ☐ No ☐

3. Name: _____

   Number of Examinations per week: _____

   Do you have College approval to interpret EEGs: Yes ☐ No ☐

Technical Staff (Receiving Site) (Use a duplicate page if there are more than two technical staff.)

1. Name: _____

   Training: _____

   Educational Institution: _____

   Dates: _____

   Place of Neurophysiology Training: _____

   Dates: _____

   Additional Neurophysiology Experience: _____

   Place: _____ Dates: _____

   Do you perform EEG Procedures: Yes ☐ No ☐ State number per month: _____

   Are you currently registered with CBRET? ☐ ABRET? ☐ OTHER? ☐

   If other, please state: _____

2. Name: _____

   Training: _____

   Educational Institution: _____

   Dates: _____

   Place of Neurophysiology Training: _____

   Dates: _____

   Additional Neurophysiology Experience: _____

   Place: _____ Dates: _____

   Do you perform EEG Procedures: Yes ☐ No ☐ State number per month: _____

   Are you currently registered with CBRET? ☐ ABRET? ☐ OTHER? ☐

   If other, please state: _____

List of additional sites studies are transmitted from:

(Note: A separate accreditation process is requested for each transmitting site located in Alberta.)

1. Name of Site: _____

2. Name of Site: _____

3. Name of Site: _____

General Information – Transmitting Site

Part C – Facility

Name: _____

Address: _____

_____

Telephone Number: _____ Fax Number: _____

No. Of Studies Transmitted/Month: _____

Part D - Personnel

Medical Director

Name: _____

Medical Qualifications: _____

Technical Staff

1. Name: _____

   Training: _____

2. Name: _____

   Training: _____

3. Name: _____

   Training: _____

Part E – Equipment

Receiving Site

	Type of Equipment	Age of Equipment	Manufacturer	Model Number
EEG				

Transmitting Site

	Type of Equipment	Age of Equipment	Manufacturer	Model Number
EEG				

Type of Electrodes: _____

Part F – Signature

Medical Director (Receiving Site)

Name (please print): _____

Signature: _____ Date: _____

Print Form