Clinical Accreditation Services

CPSA Notification - Change to Facility

Facility Name: ______________________ **Facility Number:** ______________

CHANGE TO FACILITY INFORMATION

(Please check and provide **the updated information only**):

☐ Facility Name: ______________________

☐ Testing/Procedures/Anesthesia: ______________________

☐ Medical Director: ______________________

☐ Full Address: ______________________

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☐ Phone: ______________________

☐ Email: ______________________

NOTES:

SIGNATURE

I have reviewed and confirm the above facility information is accurate.

Medical Director/Designate Name (please print): ______________________

Date: ______________________

Signature: ______________________

Please submit completed form to the College:

Accreditation Department
College of Physicians & Surgeons of Alberta
2700, 10020 – 100 Street NW
Edmonton, Alberta T5J 0N3

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