College of Physicians & Surgeons of Alberta

Hyperbaric Oxygen Therapy
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 #
Qualifications		
Address for correspondence		
Phone		
E-mail		

HBOT Facility Supervisor/Manager

Name	
Qualifications	
Phone	
E-mail	

Assessment Contact

Name	
Phone	
Address (if different from facility)	
E-mail	

Financial Contact

Name	
Phone	
Address (if different from facility)	
E-mail	

Technical Personnel:

Hyperbaric Technologist

	FTE	Completed 40 hour course approved by the Undersea & Hyperbaric Medical Society?
Technologists		

* Please submit copies of:
  - HCP CPR
  - Evidence of completion of the Undersea & Hyperbaric Medical Society course
  - Practice permit

SECTION 3 – SERVICES

Description of Services provided

SECTION 4 –PHYSICIANS SUPERVISING HBO THERAPY

List of Physicians providing therapy in the Facility

Physician Name	**Registration #**

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 Technologist's CPR
- Copies of Technologist's practice permits
- 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 – SPACE

Total Space _____m^2 or _____ft^2

SECTION 8 - SIGNATURE

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

Medical Director/Designate Name (please print): _____

Date: _____

Signature: _____

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