College of Physicians & Surgeons of Alberta

Neurophysiology Testing
New Facility Application

SECTION 1 - GENERAL FACILITY INFORMATION

Facility Name	
Neurophysiology Testing	EEG ☐ EMG ☐ EP ☐
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 #
Approvals	EEG ☐ EMG ☐ EP ☐	
Address for correspondence		
Phone		
E-mail		

Consultant (if applicable)

Name		Registration #
Approvals	EEG ☐ EMG ☐ EP ☐	
Address for correspondence		
Phone		
E-mail		

Laboratory 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:

List the number of full time equivalents:		BRETC Certified	AETC Membership	ACMDTT Registration
EMG Technologist				
EEG Technologist				
EP Technologist				

*Submit copies of registration and/or certifications.

SECTION 3 - SERVICES PROVIDED

	Description
EEG	
EMG	
EP	
Visual	
Auditory	
Somatosensory	

SECTION 4 - INTERPRETERS

List of Physicians Interpreting Neurophysiology Studies in the Laboratory

Physician Name	Registration #	Approval (EMG, EEG, EP)

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)
- Copy of Policy and Procedure Manual (do not send original)
- List of mobile testing locations if applicable
- Registration and/or certifications for applicable technical staff (ACMDTT, BRETC, AETC, etc.)
- Practice permits for all technical staff

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 (e.g. EMG, EEG, EP equipment which requires quality checks and/or calibration)	Year of Manufacture	Serial/Model 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: _____

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