College of Physicians & Surgeons of Alberta

Application Form
Change in Scope of Practice

Applicant Information:

Name: _____ CPSA Registration Number: _____

Email: _____ Phone Number: _____

What is your current scope of practice? *(please describe)*

Do you want to <u>restrict</u> OR <u>expand</u> your current scope of practice? ☐ Restrict ☐ Expand

Please explain the proposed changes to your scope of practice:

Do you have formal training related to your proposed practice area?
(*please describe and identify when you underwent the related formal training)*

Do you plan to take formal training related to your proposed practice area?
(please describe proposed formal training)

Is your proposed change in scope of practice in a group practice or hospital setting?
(please identify and explain)

Signature: _____ Date: _____

PRINT AND SIGN FORM

Please return completed form to CPSA PPAP DEPARTMENT
Email: ppap@cpsa.ab.ca