



Application Form Change in Scope of Practice

Applicant Information:

Name: _____
Email: _____

CPSA Registration Number: _____
Phone Number: _____

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

Do you want to restrict OR expand 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: _____