cpsa
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Methadone Approval Application Form

Physician Information:

Surname: _____ Given Names: _____

CPSA registration number: _____ Specialty: _____

Postgraduate Training: _____

Primary Practice Address: _____

City: _____ Province:_____ Postal: _____

Phone Number (with area code): _____ Fax Number: _____

Email Address: _____

Mailing Address (if different from above): _____

City: _____ Province:_____ Postal: _____

Type of Practice: ☐ Solo ☐ Group

Methadone Approval for: ☐ Opioid Use Disorder (OUD) - General ☐ Opioid Use Disorder (OUD) – Patient Specific
☐ Analgesia - General ☐ Analgesia – Patient Specific

If patient specific, name of patient(s): _____

Qualifications and Experience:

Describe qualifications and experience with methadone. E.g., courses, seminars, conferences, etc.
(See requirements & needed support documentation)

☐ I affirm that, to the best of my knowledge, the information on this form is true and accurate. I also understand methadone approvals must be renewed every 3 years by re-applying to the College.

Signature: _____ **Date:** _____
(dd/mmm/yyyy)

Send completed application by mail or fax:

CPSA Methadone Program, 2700, 10020 100 Street NW, Edmonton AB T5J 0N3
Fax: 780-420-0651

Questions? Email: OATinfo@cpsa.ab.ca or call 1-800-561-3899

PRINT & SIGN FORM