CPSA
COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

# Sleep Medicine
## Physician Approval Sleep Medicine Diagnostics

*(Requirements for Alberta Diagnostic Sleep Medicine Facilities and Services are as per the College of Physician & Surgeons Sleep Medicine Standards Section: Appendix A)*

*(Check all that apply)*
I am applying to be a ☐ Medical Director ☐ Interpreter ☐ Both

For the following services:
- ☐ Adult Comprehensive Polysomnography
- ☐ Adult Unattended Polysomnography
- ☐ Adult Complex Respiratory Patients
- ☐ Adult Home Sleep Apnea Testing
- ☐ Pediatric Comprehensive Polysomnography
- ☐ Pediatric Complex Respiratory Patients

**APPLICANT INFORMATION** (Please Print)

CPSA Registration Number: ____________________________

Last Name: ___________________________________________ Given/First Names: __________________________

Street Address: ___________________________________________________________________________

City: ________________________________________________ Postal Code: ___________________

Telephone Number: (______) ___________________E-mail Address: _______________________________________

1. Specialty:
   - ☐ Internal Medicine
   - ☐ Adult Psychiatry
   - ☐ Family Medicine
   - ☐ Adult Neurology
   - ☐ Otolaryngology
   - ☐ Pediatric Psychiatry
   - ☐ Pediatric Neurology
   - ☐ Pediatric Respirology
   - ☐ Developmental Pediatrics
   - ☐ Cardiology
   - ☐ Respirology
   - ☐ Pediatrics

2. Qualifications in Sleep Medicine:
   - ☐ Certification in Sleep Medicine from the American Board of Sleep Medicine
   - ☐ Somnologist - Expert in Sleep Medicine from the European Sleep Research Society (ESRS)
   - ☐ Other (please specify): ____________________________________________________________________

3. My training is as follows:

| Institution | Dates | |
|---|---|---|
| | From (Month/Year) | To (Month/Year) |
| | | |
| | | |
| | | |

4. I have enclosed a letter confirming training and competence from the program provider Yes ☐ No ☐
   ***(Note: This evidence of training and competence is required.)***


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5. My clinical experience is as follows:

| Institution | Dates | |
|---|---|---|
| | From (Month/Year) | To (Month/Year) |
| | | |
| | | |
| | | |
| | | |
| | | |

| Type/Description of Procedure | Check only those procedures for which you are requesting approval. | Total number of procedures performed in the past year. **Numbers <u>must</u> be provided for requests to be processed.** | |
|---|---|---|---|
| | | **ADULT** | **PEDIATRIC** |
| A. Attended Polysomnography | | | |
| • Standard Comprehensive Polysomnogram | ☐ | | |
| • Comprehensive Polysomnogram with expanded montage. | ☐ | | |
| • Multiple Sleep Latency Test (MSLT) | ☐ | | |
| • Maintenance of Wakefulness Test (MWT) | ☐ | | |
| B. Additional Respiratory Physiologic Monitoring Polysomnography | | | |
| o Esophageal Manometry | ☐ | | |
| o Quantified Oronasal Airflow | ☐ | | |
| o Continuous Transcutaneous Carbon dioxide ($TCO_2$) Monitoring | ☐ | | |
| o Arterial Blood Gas Measurement | ☐ | | |
| C. Unattended Polysomnography | ☐ | | |
| D. Home Sleep Apnea Testing | ☐ | | |
| E. Actigraphy | ☐ | | |
| F. CPAP titration | ☐ | | |
| G. Bi-level PAP titration | ☐ | | |

6. **Expected Practice Start Date:** ____________________________________________


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**Applicant Signature:** _________________________________ **Date:** ______________________________

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7. **Documentation Submissions:**

   Please sign, scan and email your completed application and documentation (together as one package) to sleep.medicine@cpsa.ab.ca


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