CPSA
COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Application for Modality Re-Approval
Echocardiography Re-Approval

APPLICANT INFORMATION

Applicant Name:______________________________________
Street Address:______________________________________
____
City:____
Telephone Number: (______)___________________________
Email:____

CPSA Registration Number: ______________
Postal Code:____________________________
Fax Number: (____)______________________

Specialty:______________________________

PLEASE REVIEW THE REQUIRED EXPERIENCE AND TRAINING:

Active practice *refers to performing a minimum of 100 echocardiography cases a year, or in the case of a physician limiting their practice to transesophageal echocardiography (TEE), a minimum of 60 cases a year.*

	Out of Active Practice for the last TWO years	**Out of Active Practice or the last FIVE years**
Re-Approval in Echocardiography	You must complete a minimum of **one (1)** month retraining. This includes completion of at least 100 studies. You must provide a letter from the preceptor attesting to competence.	Must complete a minimum of **three (3)** month retraining which includes completing at least 300 studies. You must provide a letter from the preceptor attesting to competence.

Criteria used as a guide when reviewing requests for Echocardiography:

- Original training;
- Training program content, including these expectations:
    - Faciliy is affiliated with a university,
    - Facility workload (volume and caseload),
    - Review of submitted logbook of cases
- Preceptor credentials and details in the letter attesting to satisfaction with the applicant's abilities;
- **Current guidelines, recommendations and examinations championed by the cardiovascular section of the Canadian Anesthesiologists' Society (CAS), the Canadian Society of Echocardiography (CSE), and the Canadian Cardiovascular Society (CCS).

PLEASE NOTE: ***Your program provider must submit documentation to confirm your training and competence before the College can process your application. Please outline training time chronologically in months.***

TRAINING HISTORY:

DATE FROM (month/year)	**TO** (month/year)	**INSTITUTION**

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EXPERIENCE HISTORY:

DATE FROM (month/year)	**TO** (month/year)	**INSTITUTION**

Expected Practice Date: ___________________________

A physician must not provide prescribed health services unless the facility is accredited. (HPA Section 8.1)*

Applicant Signature: _____________________________________ Date _____________________________________

Please complete and return to:
ATTN: Virginia Perry, Accreditation Assistant, Diagnostic Imaging Accreditation Services
College of Physicians & Surgeons of Alberta by fax: 780-428-2712, by mail:
2700 - 10020 100 ST NW, Edmonton AB T5J 0N3 or email:
virginia.perry@cpsa.ab.ca

An incomplete application will delay re-approval.
Questions? Contact the College's Accreditation Department at
780-969-4997 or 1-800-320-8624 ext. 5002 (in Alberta).

Your privacy is important to us!

We collect, use and/or disclose your personal information with your consent unless otherwise authorized or required by legislation. As per our CPSA Privacy Statement, we collect and use your personal information to do our College work, which is to protect the public and to guide and regulate Alberta physicians.