

# Application for Modality Re-Approval Magnetic Resonance Imaging (MRI)

## 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 CT cases/year*

|  | Out of Active Practice* for the last<br>TWO years   | Out of Active Practice* for the last<br>FIVE years   |
|--|---|--|
| <b>Re-Approval in<br/>Magnetic Resonance Imaging</b> | You must complete a minimum of <b>one (1)</b> month retraining at an accredited MRI facility completing a minimum of 100 cases and provide a letter from the preceptor attesting to completion. | You must complete a minimum of <b>three (3)</b> months retraining at an accredited MRI facility completing a minimum of 300 cases and provide a letter from the preceptor attesting to completion. |

## Criteria used as a guide when reviewing requests for MRI re-approval

- Original training
- Experience in practice
- Extent of related activity while away from relevant practice
- Retraining program content, including these expectations:
  - ♦ Completion over a reasonably brief time (i.e. months, not years)
  - ♦ Review of relevant current literature,
  - ♦ Method of competence evaluation,
  - ♦ Degree of supervision
- Preceptor credentials and details in the letter attesting to satisfaction with your abilities

**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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|------------------------|-----------------|-------------|
|                        |                 |             |
|                        |                 |             |
|                        |                 |             |

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 Marshall, 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.marshall@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.