COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Application for Modality Re-Approval
Nuclear Medicine

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 nuclear medicine cases/year*

	Out of Active Practice* for the last TWO years	**Out of Active Practice* for the last FIVE years**
Re-Approval in Nuclear Medicine	You must complete a minimum of **one (1)** month retraining at an accredited nuclear medicine residency training program and provide a letter from the preceptor attesting to completion and your competence	You must complete a minimum of **three (3)** months retraining at an accredited and nuclear medicine residency training program provide a letter from the preceptor attesting to completion and your competence.

Criteria used as a guide when reviewing requests for nuclear medicine 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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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.