COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Vestibular Testing
Application for Approval to Direct Vestibular Disorder Laboratory

APPLICANT INFORMATION (Please Print)

CPSA Registration Number: _____

Last Name: _____ Given/First Names: _____

Street Address: _____

City: _____ Postal Code: _____

Telephone Number: (_____) _____ Fax Number: (_____) _____

E-mail Address: _____

1. Specialty: ☐ Neurology ☐ Otolaryngology

2. I have completed the minimum equivalent of one year extra training in neurotology:

   ☐ Yes ☐ No

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.

   (Note: This evidence of training and competence is required.) Yes ☐ No ☐

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5. My experience is as follows:

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

6.

Type/Description of Procedure	Check only those procedures for which you are requesting approval.	Total number of procedures performed in the past year. **Numbers must be provided for requests to be processed.**
A. Basic ENG	☐	
• EOG calibration	☐	
• Saccade test	☐	
• Spontaneous and gaze evoked nystagmus	☐	
• Ocular pursuit testing	☐	
• Positional nystagmus	☐	
• Bithermal caloric test	☐	
• Failure of fixation suppression	☐	
B. Specialized Procedures	☐	
• Rotation testing (rotating chair)	☐	
• Posturography	☐	
• Optokinetic nystagmus (OKN)	☐	
• Others	☐	

7. **Expected Practice Start Date:** _____

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Applicant Signature: _____ **Date:** _____

Please return your completed application and required documents (together as one package) to the College of Physicians & Surgeons of Alberta by fax: 780-428-2712 or by mail:
2700 - 10020 100 ST NW, Edmonton AB T5J 0N3

Print Form