COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Non-Hospital Surgical Facility – Application for Privileges
Stem Cell Regenerative Therapy – Adipose-Derived Stem/Stromal Cells (ADSC) Procedure Checklist

This document must be completed and attached to your NHSF Application for Privileges. ONLY check (✓) those procedures for which you are requesting NHSF approval. You must also indicate the number of procedures performed in the past 12 months in all NHSFs and hospitals. Please note that only those Stem Cell Regenerative Therapy procedures the facility is approved to perform will be granted.

Applicant Last Name: _____ Given/First Names: _____

Facility Name: _____

Sub-specialty Procedure	Anatomical Area(s) (specify each)	**ONLY** check (✓) those procedures for which you are requesting NHSF approval.	You **MUST** include total number of procedures performed in the past 12 months and where.
		check (✓)	*# of procedures (e.g. 8 at John Smith NHSF, 2 at U of A Hospital)*
ORTHOPEDIC			
Degenerative Conditions – Please specify the type (i.e. Arthritis)			
		☐	
		☐	
		☐	
Acute Injury – Please specify the type (i.e. Shoulder GL Tear)			
		☐	
		☐	
		☐	

Chronic/Over-use Injury – Please specify the type (i.e. Runner's knee)			
		☐	
		☐	
		☐	
Intraoperative Adjunct Treatment – Please specify the paired procedure (i.e. ACL Reconstruction)			
		☐	
		☐	
		☐	
DERMATOLOGY/PLASTIC SURGERY			
Cosmetic Skin Rejuvenation – Please specify the type (i.e. Vampire Facelift)			
		☐	
		☐	
		☐	
Traumatic Skin Defect – Please specify the type (i.e. Scars, Burns, Non-healing Wound)			
		☐	
		☐	
		☐	

Intraoperative Adjunct Treatment – Please specify the paired procedure (i.e. Hair Transplantation)			
		☐	
		☐	
		☐	
OTHER			
Patient Condition – Please specify the type (i.e. Glaucoma)			
		☐	
		☐	
		☐	
Intraoperative Adjunct Treatment – Please specify the paired procedure (i.e. Type I Diabetes)			
		☐	
		☐	
		☐	

Additional Information Required with this Procedure Checklist:

1. I am a specialist in:

☐ Orthopedics
☐ Family Medicine
☐ Dermatology
☐ Plastic Surgery
☐ Physician Medicine and Rehabilitation
☐ Anesthesiology
☐ Radiology
☐ Other - Please Specify:

2. Have you just completed your stem cell regenerative therapy training within the past year? Yes ☐ No ☐

3. Part and/or all of my formal training in stem cell regenerative therapy was obtained at:

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

4. The stem cell collection system utilized will be:

☐ Commercially prepared kit ☐ In-house assembled system ☐ Both

5. Physicians who perform Regenerative Therapy in an NHSF shall:

   a. Be a physician licensed to practice medicine in Alberta;

   -and -

   b. Be certified as a specialist in the appropriate field with evidence of recognized training in Regenerative Therapy;

   -or-

   c. Have evidence of appropriate and sufficient training with experience that is suitable to the Registrar.

6. A satisfactory postgraduate training program acceptable to the Registrar for sufficient training and experience shall **include clear demonstration and evidence of**:

    a. Peer training preceptors with credentials acceptable to the Registrar;

    b. Both didactic and hands-on training;

Indicate type of didactic training: Lecture/Home study/Self Directed	Specify Formal Institution Program and/or Self Selected Peer Preceptorship	Dates		Hours
		From (Month/Year)	To (Month/Year)	

Indicate type of hands-on training (i.e. knee joint)	Specify Formal Institution Program and/or Self Selected Peer Preceptorship	Dates		Number of Procedures
		From (Month/Year)	To (Month/Year)	

c. A letter from the program provider or preceptor providing a clear description of the amount of training and the nature of the hands-on training. The letter must address each of the following for each procedure requesting approval for:

i. The selection of procedures;
ii. The preparation of patients;
iii. Maintenance of asepsis in non-hospital settings;
iv. Intra-operative patient monitoring;
v. Post-operative care and follow-up;
vi. Quality improvement in surgical services;
vii. Hands-on training in the surgical technique of bone marrow aspiration and/or liposuction;
viii. Processing and delivery of the aspirate.

An incomplete application will delay processing. If you have any questions completing this form, please contact our Accreditation Department at 780-969-5002 or 1-800-320-8624 ext. 5002 (in Alberta).

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Applicant Signature: _____ **Date:** _____

Medical Director 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