

Please complete this document and attach to your NHSF Application for Privileges if you are applying for Retrobulbar Block (RB) approval.

Applicant Last Name: _____

Given/First Name: _____

CPSA Registration Number: _____

Medical Director: _____

Facility Name: _____

1. Have you just completed your residency and/or fellowship within the last year? Yes No

AND/OR

Have you been practising less than one year? Yes No

If **yes**, please provide two reference letters attesting to your skill and judgement to perform Retrobulbar Blocks.

If **no**, please complete the remaining questions.

2. How many years have you been in clinical practice? _____
3. How many years have you been doing RBs? _____
4. How many RBs have you done in the last year? _____
5. How many years has it been since you last did one? _____
6. How many have you done (approximately) in your career? _____

Medical Director Signature: _____

Date: _____