Privilege Credentialing Form

This form is to be completed by physicians seeking to obtain privileging or approval within an accredited medical facility. Once completed and signed by the physician/applicant, this form is to be submitted to the facility named below.

Facility email address: _____

(To be entered by the facility—this is the email address the applicant should use when submitting this form)

To be completed by the facility (office use only)	
Facility Information	
Facility Name:	Facility ID:
Submission Date:	Requested Start Date:
Medical Director Information	
Last Name:	Given/First Names:
CPSA Reg. Number:	Email:

To be completed by the applicant:

Applicant Information

Last Name: _____ Given/First Names: _____

CPSA Reg. Number: _____ Telephone Number: _____

Address: _____

City: _____ Province: _____

Postal Code: _____ Email: _____

Specialty(ies)

Training (Residencies/Fellowships)		
Institution	**From (Month/Year)**	**To (Month/Year)**

Additional Training, Skills, Certifications, Courses Such as BLS (HCP or equivalent), ACLS, PALS, difficult airway course, laser training, radiation safety training, American Board of Cardiovascular Medicine – Advanced ECG Board Certification, RCPSC Area of Focused Competency, etc.		
Institution/Course	**From (Day/Month/Year)**	**To (Day/Month/Year)**

Experience		
Healthcare Facility	**From (Month/Year)**	**To (Month/Year)**
Current Approvals/Privileges		
AHS/Hospitals in other provinces		

Attach a copy of the applicant's most current hospital "Privileges Summary."

Note: "Privileges Summary" is accessible to the physician via their hospital's intranet/portal or the medical affairs department.

Accredited Non-Hospital/Community-Based Facilities (up to 3 current & most relevant)			
Facility:		CPSA Facility ID:	
City		From (Date) :	
Privileges/Approval			
Facility:		CPSA Facility ID:	
City		From (Date) :	
Privileges/Approval			

Facility:		CPSA Facility ID:	
City		From (Date):	
Privileges/Approval			

References

In the sections below, provide the name, professional details and contact information of **two professional references** you have worked with within the last three years. One must be the head of a hospital department/division or a senior medical administrator of the organization in which you most recently worked, or the program director if you have recently completed post-graduate training. The other must be a professional colleague you currently or recently worked with within your specialty. References must have current knowledge of your practice.

If you are requesting privileges/approvals requiring additional skills/training/competency outside your core speciality competencies, at least one reference must specifically address recent training and/or experience in these areas.

References may be contacted. Additional references may be requested.

Head of hospital department or division/senior medical administrator/program director

Name: _____ Organization: _____

Position: _____ Email: _____

Address: _____

City: _____ Province: _____

Postal Code _____ Telephone Number: _____

Medical colleague

Name: _____ Organization: _____

Position: _____ Email: _____

Address _____

City _____ Province: _____

Postal Code _____ Telephone Number: _____

Requested Privileges/Approval		
☐ Provisional (new medical staff, Medical Director to determine timeframe)		
☐ Temporary (defined time period and/or specified number of cases)	End date:	

Check All that Apply to the Specific Physician	
☐ Non-Hospital Surgical Facility (NHSF) Privileges	
☐ Anesthesiology (specialist)	
☐ Anesthesiology (non-specialist)	
☐ IV Sedation via Surgeon	
☐ Assisted Reproductive Technology (ART)	
☐ Dermatologic Surgery	
☐ General Surgery	
☐ Gynecologic	
☐ Off-label Use of Sedatives & Anesthetics	
☐ Ophthalmologic Surgery	
☐ Orthopedic Surgery	
☐ Extended Stay Surgery	
☐ Otolaryngologic Surgery	
☐ Plastic Surgery	
☐ Stem Cell Therapy	
☐ Urologic Surgery	
Procedures	☐ **Completed procedure list attached (NHSF Procedures by Scope)** **If you check this box, you MUST submit the NHSF Procedures by Scope Form**
☐ Cardiac Stress Testing ☐ Adult stress testing ☐ Pediatric stress testing (non-pharmacological only) ☐ Non-pharmacological stress testing ☐ Pharmacological stress testing (Inotropic and Vasodilator)	
☐ Diagnostic Imaging ☐ Computed Tomography (excluding Cardiac CT) ☐ Cardiac CT (Level 2) ☐ Cardiac CT (Level 3) ☐ Echocardiography ☐ Echocardiography (Adult only) - Including Transesophageal (TEE) only ☐ Echocardiography (Adult only) - Including Stress only ☐ Echocardiography (Adult only) – Including Contrast only ☐ Echocardiography (Adult only) – Including TEE and Stress, excluding Contrast ☐ Echocardiography (Adult only) – Including Stress and Contrast, excluding TEE ☐ Echocardiography (Adult only) – Including TEE and Contrast, excluding Stress ☐ Perioperative Transesophageal Echocardiography (TEE) for Anesthesiologists (Level 2) Adult only ☐ Perioperative Transesophageal Echocardiography (TEE) for Anesthesiologists (Level 3) Adult only ☐ Magnetic Resonance Imaging (MRI) – General (excluding Cardiac) ☐ Magnetic Resonance Imaging (MRI) – Restricted – Cardiac	

☐ Nuclear Medicine – General ☐ Nuclear Medicine – Restricted – Cardiac ☐ Positron Emission Tomography ☐ Ultrasound General/Full ☐ Ultrasound Restricted – in focused area of US imaging relevant to area of practice/specialty (for example, but not limited to MSK, OB/GYN, Vascular, Urology) ☐ Bone Densitometry ☐ Mammography ☐ Radiography ☐ Fluoroscopy (Diagnostic Radiologist) ☐ Fluoroscopy (Non-Radiologist) ☐ Pediatric Imaging
☐ Hyperbaric Oxygen Therapy ☐ Adult ☐ Pediatric (limited to 14 years of age to 18 years of age)
☐ Neurophysiologic Testing ☐ Adult ☐ Pediatric ☐ Electroencephalography (EEG) ☐ Electromyography (EMG) ☐ Evoked Potentials (EP) ☐ Visual ☐ Auditory ☐ Somatosensory
☐ Pulmonary Function Testing ☐ Level II ☐ Level III ☐ Level IV
☐ Sleep Medicine Diagnostic Testing ☐ Adult Comprehensive Polysomnography (Level 1) ☐ Polysomnography for Complex Adult Respiratory Patients (Level 1) ☐ Pediatric Comprehensive Polysomnography (Level 1) ☐ Polysomnography for Complex Pediatric Respiratory Patients (Level 1) ☐ Adult Unattended Polysomnography (Level 2) ☐ Adult Home Sleep Apnea Testing (Level 3)

In applying for privileges or approval you acknowledge awareness of the requirements of Section 21 of the *Physicians, Surgeons and Osteopaths Regulation* which states: "a physician, surgeon or osteopath must only perform a restricted activity that the physician, surgeon or osteopath is competent to perform and that is appropriate to the clinical circumstance and that regulated member's scope of practice."

Declaration		
☐ Yes	☐ No	I have professional liability protection through the Canadian Medical Protective Association (CMPA) that extends to all areas of my practice.

☐ Yes	☐ No	I have not had my zone, hospital or non-hospital privileges revoked, suspended or restricted in any way, nor have I surrendered or altered my privileges as a result of potential revocation, suspension or restriction.
☐ Yes	☐ No	I have not had any disciplinary actions, complaint investigations, practice reviews, formal reviews, or other proceedings initiated, pending or completed against me by CPSA, a hospital or non-hospital facility.
☐ Yes	☐ No	I have not had any disciplinary actions, complaint investigations, practice reviews, formal reviews, or other proceedings initiated, pending or completed against me by Alberta Health or a licensing authority. This does not include the College of Physicians and Surgeons of Alberta.
☐ Yes	☐ No	I have not had any civil court make a finding against me or entered into an out-of-court settlement relevant to my medical practice.
☐ Yes	☐ No	I have not been charged with a criminal or similar offence. (This includes if you have received an absolute or conditional discharge, if the charges were dismissed, stayed, withdrawn, or did not result in a conviction. This also includes charges for which you were granted a pardon.)
☐ Yes	☐ No	I have not been convicted of a criminal or similar offence.
☐ Yes	☐ No	I have not had a peace bond or restraining order issued against me that is relevant to my medical practice.
☐ Yes	☐ No	I am willing to provide a Police Information Check

If you answered no to any of the above, please provide full details in a separate document. Answering no to any of the questions does not necessarily preclude appointment to the medical staff. The Medical Director will use this information to assess your ability to deliver appropriate patient care.

Acknowledgement and Consent

I understand and agree that I have the burden of providing adequate, current and correct information for the proper evaluation of my professional competence, character, ethics, qualifications, licensure, insurance and other qualifications. I understand and agree to respond to any inquiries about such information to the satisfaction of the facility Medical Director.

I am a registrant in good standing with CPSA.

I agree to:

- abide by the *Code of Ethics and Professionalism* as adopted by CPSA at all times during my appointment to the medical staff.
- maintain and provide proof of professional liability insurance protection appropriate to my professional activities within the non-hospital facility.
- inform the facility Medical Director of any changes that would affect my ability to practice medicine and the type of practice I undertake while a member of the medical staff (e.g., licensure, professional liability insurance coverage, my health, qualifications, change of scope, immigration status).
- release the facility, employees, agents, staff and medical staff from all liabilities and claims for losses sustained in connection with evaluating my application for medical staff membership, except where such losses are caused by their gross negligence or intentional misconduct.

I acknowledge that:

- if appointed to the medical staff, I will fulfill my responsibilities as a member of the medical staff, as defined in the CPSA Bylaws, Standards of Practice, Accreditation Standards, applicable legislation/codes, and the Medical Staff Rules of the facility.
- any breach of the above agreement, or any misrepresentation or material omission on my part in completing this application may result in the denial, revocation or suspension of my appointment to the medical staff.

I understand that the facility will collect, use and disclose personal information about me for the purposes of:

- evaluating my application for medical staff membership.
- administering and maintaining my medical staff membership and relationship with the facility including maintaining privileges/practice activities and access to information systems and equipment.
- facility planning.

I consent to the following:

- the facility may contact the references whose names I have provided for the purpose of evaluating my application for appointment/reappointment/employment and privileges/practice activities
- my personal information will be stored by the facility and may be shared with other Alberta health authorities and their affiliates, and the CPSA for the purposes stated above

Applicant Authorization

In signing this document:

- I acknowledge I have read and understand the points in the above declaration and acknowledgment.
- I declare that I have requested only those privileges for which by education, training and current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at the non-hospital facility I am applying to.
- I declare that the information submitted by me in this application is true to the best of my knowledge.

I authorize the Medical Director to revoke any privileges or approval to practice at the facility if it subsequently appears that I have, by any omission or commission, given false, misleading or ambiguous information in respect to any question on this application

Applicant Signature: _____ **Date:** _____

Please submit completed form to the facility named on Page 1.

The personal information on this form is collected under the legal authority of section 33(c) of the *Freedom of Information and Protection of Privacy Act*. The information will be used by or disclosed for employment purposes.

Privileges/approvals are granted by the Medical Director and are based on (but not limited to) the physician's competencies, training, specialty/subspecialty, skillsets, abilities, experience, active practice, and scope of practice within their regulatory body. CPSA may be consulted by the Medical Director to provide a recommendation to assist with their decision process.