THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

APPLICATION FOR PHYSICIANS PROPOSING TO CHANGE THEIR SCOPE OF PRACTICE

Dear Applicant,

The College is pleased to provide you with an application package to apply to change your scope of practice under the College's Changing Scope of Practice policy.

This application requires review and approval by staff and Medical Advisors, which may take up to 5 weeks, more if information is missing. **You must receive approval from the College before you begin.**

Changing scope of practice typically involves graded clinical supervision, as outlined in the *Guidelines for College-Directed Supervision*, and assessment of your practice. If successful, it leads to approval to practice independently in the area of practice that was assessed.

This application package contains the following:

- Changing Scope of Practice Process and Timelines
- List of Requirements
    - please note there may be additional requirements listed for each of the Minimum Expectations documents, and these can be found here.
- Application Form for Physicians Proposing to Change Their Scope of Practice

Should you have any questions regarding this process, please consult our Changing Scope of Practice Process and Timelines document, or contact the Inquiries Section in the Applications and Credentials Department at (416) 967-2617, Monday through Friday 9am to 5pm.

Application packages may be submitted directly by mail or emailed to: cosre@cpso.on.ca

The College looks forward to receiving your application, and wishes you success in your changing scope of practice process.

Sincerely,

Inquiries Section
Applications and Credentials Department

80 College Street, Toronto, Ontario M5G 2E2 Tel: (416) 967-2600 Toll Free: (800) 268-7096 Fax: (416) 961-3330

CHANGING SCOPE OF PRACTICE – REQUIREMENTS CHECKLIST

This checklist outlines requirements and is provided as a reference to organizing your application.

All Requirements must be submitted to the College as a Complete Package

1. Application Form
2. Updated CV
3. Updated CV of proposed Clinical Supervisor(s)
4. Draft Individualized Education Plan (IEP)
    - Sample IEP for Family Medicine
    - IEP template
5. Additional (Relevant) Training Documents/Certificates

***Please note there may be additional requirements listed for each of the Minimum Expectations documents, and these can be found here.**

College of Physicians and Surgeons of Ontario
Application Form for Physicians Proposing To Change Their Scope of Practice

The purpose of this questionnaire is to provide the College with the most current information about you and your current practice, as well as your proposed "scope of practice." You are requested to complete this application in accordance with the CPSO Policy Statement "Requirements When Changing Scope of Practice" approved by CPSO Council in November 2000. The information you provide will be reviewed by the staff who support the Re-entering Practice process, and related Committees.

The CPSO may use this information for evaluation and research purposes to improve our quality improvement programs. All information made available to individuals or organizations external to College will be in aggregate, unidentifiable formats.

SURNAME (as indicated on CPSO register): _____

GIVEN NAME(S)(as indicated on CPSO register): _____

CPSO NUMBER:_____ **DATE OF BIRTH (day/month/year):**____/____/____ **SEX (M/F):**_____

MEDICAL DEGREE FROM UNIVERSITY OF: _____ **YEAR:** _____

Year internship/residency training completed: _____
Total years of post graduate training (internship/residency): _____

College of Family Physicians of Canada: Certificant Yes ◉ No ○ Year _____ Member Yes ○ No ○

Royal College of Physicians and Surgeons of Canada: Fellowship Yes ○ No ○ Year _____ Specialty _____

List of hospitals with which you are affiliated:
_____ Admitting Privileges Yes ○ No ○
_____ Yes ○ No ○

Mailing Address

Hospital/Facility Name (if applicable)		***Street and Number***	***Suite Number***
City	***Province***	***Postal Code***	***Email Address***
Office Telephone		***Home Telephone***	***Fax Number***

Current Primary Practice Address *(location in which you see the majority of your patients)*

Hospital/Facility Name (if applicable)		***Street and Number***	***Suite Number***
City	***Province***	***Postal Code***	***Email Address***
Office Telephone		***Home Telephone***	***Fax Number***

PART I: WHAT IS YOUR PROPOSED PRACTICE LOCATION?

***PROPOSED* PRACTICE ADDRESS** (*if different from current location -- location in which you will see the majority of your patients)*

Hospital/Facility Name (if applicable)		***Street and Number***	***Suite Number***
City	***Province***	***Postal Code***	***Email Address***
Office Telephone		***Home Telephone***	***Fax Number***

PART II: TELL US ABOUT YOUR CURRENT AND PROPOSED PRACTICE STRUCTURE

Please complete the following sections to the best of your ability. When answering the questions below, please note that:
***Current Practice** = your current clinical activities*
***Proposed Practice** = your current practice that you plan to continue and/or any new area of practice that you are proposing to add*

With reference to those questions about your proposed "scope of practice," please indicate "unknown" if you are unable to answer the question. Please do not leave blanks.

WITH WHOM DO YOU WORK IN YOUR CURRENT OFFICE PRACTICE AND WITH WHOM DO YOU PLAN TO WORK IN YOUR PROPOSED PRACTICE?

1. Please indicate the number of full-time and part-time personnel that you currently work with on a regular basis (daily/weekly) within your current office practice, as well as what you anticipate will be the situation in your proposed practice:

	CURRENT		PROPOSED		
FOR OFFICE PRACTICE	# FT	#PT	#FT	#PT	Unknown
Physicians					
Registered Nurses (RNs)					
Nurse Practitioners (NPs)					
Administrative Staff					
Other (please specify) _____					

2. Tell us what you share with other physicians in your current office practice as well as your proposed office practice.

FOR OFFICE PRACTICE	**CURRENT**		**PROPOSED**	
	YES	**NO**	**YES**	**NO**
Staff	○	○	○	○
Office space	○	◉	◉	○
Patient Records	◉	○	◉	○

TELL US ABOUT WHERE YOU CURRENTLY WORK AND WHERE YOU PLAN TO WORK

3. Please indicate in which location you see patients, the number of patients seen and the number of hours spent in direct patient contact during a **typical work-week**. Please also describe the number of patients, and the number of hours to be spent during direct patient contact in your ***proposed*** practice setting.

	CURRENT		**PROPOSED**	
Please complete the "current" and "proposed" columns for <u>only</u> those facilities that apply. **<u>Facility</u>**	# patients seen	# hrs spent in direct patient contact	Approx. # patients expected to be seen (If unknown, please mark "unknown")	Approx # hrs to be spent in direct patient contact (If unknown, please mark "unknown")
A. Office Practice: a) Private Office				
b) Health Service Organization (HSO)				
c) Community Health Centre				
d) Family Health Network				
e) Family Health Group				
f) Walk-in Clinic; After hours Clinic, Urgent Care Setting (e.g., generally no appointments; generally episodic care, non-static patient base)				
g) Academic Family Practice Teaching Unit				
h) Locum				
B. Hospital: a) Community Hospital				
> Inpatients				
> Outpatients				
> Emergency				
> Surgical Assist				
> Day Surgery				
> Hospitalist				
b) Academic/Teaching Hospital				
> Inpatients				
> Outpatients				
> Emergency				
> Surgical Assist				
> Day Surgery				
> Hospitalist				
C. Long-Term Care Facility/Nursing Home etc.				
D. Independent Health Facility (IHF)				
E. Out of Hospital Facilities (OHP)				
F. Government Facility (jail, military, etc.)				
G. House Call Service				
H. Other (please specify)_____				

COMMUNITY SERVICES

	CURRENT		PROPOSED		
	Yes	**No**	**Yes**	**No**	**Unknown**
4. a) Do you have access to basic laboratory services (e.g., hemoglobin, urine, blood glucose analyses, etc.)?					
b) Do you have access to advanced laboratory services (e.g., bone density, cardiac stress test, electromyography, etc.)?					
c) Do you have access to basic radiological services?					
d) Do you have access to CT or MRI?					
e) Do you have access to specialists for referral?					
f) Do you have regular contact and interaction with physicians in the same discipline in your community?					
g) Does your community have one or more long term care facilities?					
h) Does your community have a Community Care Access Centre (CCAC)?					
i) Do you have access to social service agencies to support medical care for your patients?					

TELL US ABOUT THE PROPOSED CHANGES TO YOUR "SCOPE OF PRACTICE"

5. a) Have you chosen to *focus or restrict* your practice? YES ○ NO ○

b) Have you chosen to *expand* your practice? YES ◉ NO ○

c) Describe your proposed change in scope. How will it differ from your current practice?

_____

_____

_____

_____

_____

_____

_____

_____

CLINICAL ACTIVITY

6. Please describe your CURRENT and PROPOSED clinical practice **using the table of codes listed on page 6**. We would like you to reflect on your actual practice (i.e. "what you actually do"), rather than the certification(s) you may hold. If you list more than one code, please estimate the percentage of time you spend in each area.

CURRENT – What are you **currently** doing?

Code (3 digits)	0 – 10%	10 – 20%	20 – 40%	40 – 60%	60 – 80%	80% +
a)						
b)						
c)						
d)						
e) Other, please specify						

PROPOSED – What do you **propose** to do?

Code (3 digits)	0 – 10%	10 – 20%	20 – 40%	40 – 60%	60 – 80%	80% +
a)						
b)						
c)						
d)						
e) Other, please specify						

7. In a typical week, please estimate the percent of your **CURRENT** patient visits (left column) that fall within each of the following categories. Also, please estimate the percent of your patient visits that would likely fall within your **PROPOSED** practice (right column). *Please note that the total should equal 100 percent.*

CURRENT - Percent of patient visits	Category	PROPOSED – Percent of patients you anticipate in each area
	NEW PRESENTATIONS/ACUTE CONDITION MANAGEMENT – New or known patients with new complaints or condition requiring the formulation of a diagnosis in an office practice setting.	
	MANAGEMENT OF PATIENTS WITH ONGOING/CHRONIC CONDITIONS – Patients with chronic conditions requiring long-term monitoring with or without the presence of co-morbidities.	
	CONTINUITY OF CARE AND REFERRALS – Patients who you refer for treatment, surgical procedures, diagnostic procedures or otherwise, to the care of other physicians.	
	HEALTH MAINTENANCE – Patient visits for well care and preventive health maintenance (e.g. annual check-ups, screening, well baby visits, etc.).	
	PSYCHOSOCIAL CARE – Patients who you provide general counselling, psychotherapy sessions or referrals to various supportive social agencies in his/her community.	
	NEW CONSULTATIONS/PRE-OPERATIVE MANAGEMENT – New patients or known patients presenting prior to surgical/medical procedures for pre-operative examinations, testing and treatments.	
	OPERATIVE PATIENT MANAGEMENT AND PROCEDURES – Providing patients with intra-operative/procedural treatments.	
	POST-OPERATIVE MANAGEMENT AND FOLLOW-UP – Patient to whom you provide post-operative/post-procedural care, which may include follow-up of patients with conditions that may require long-term.	
	EMERGENCY MEDICINE MANAGEMENT - Patients to whom you provide care for in the emergency department.	
	OTHER (please specify) _____	
100 %	**TOTAL**	**100 %**

Table of Practice Descriptors (*To be used for Question 6)*

	ANESTHESIA		OBSTETRICS AND GYNECOLOGY		SURGERY
101	Anesthesia	504	Gynecology	802	Assistance at Surgery
103	Chronic Pain Management with anesthesia	501	Gynecologic Oncology	803	Cardiovascular Surgery
102	Chronic Pain Management without general/spinal anesthesia	502	Gynecologic Reproductive Endocrinology & Fertility	804	Clinical Associates-Surgical
		503	Gynecologic Surgery without labour and delivery	805	Colorectal Surgery
	GENERAL/FAMILY PRACTICE	506	Obstetrics	806	Cosmetic Surgery
917	Episodic Care/Urgent Care/Walk-in	505	Obstetrical Practice without labour and delivery	931	Cosmetics-non surgical procedures
201	General/Family Practice with active/admitting hospital privileges			807	General Surgery
202	General/Family practice without hospital privileges		**PEDIATRICS**	808	General Surgical Oncology
927	Hospitalist	601	Neonatology	801	Laser Surgery
921	House Calls	602	Pediatrics	809	Neurosurgery
916	Long Term Care/Nursing Homes	607	Pediatric Allergy/Clinical Immunology	810	Ophthalmology
		603	Pediatric Cardiology	811	Orthopedic Surgery
	LABORATORY MEDICINE	933	Pediatric Endocrinology	812	Otolaryngology
401	Medical Biochemistry	610	Pediatric Gastroenterology	813	Plastic Surgery
402	Medical Microbiology	615	Pediatric Gynecology	819	Sclerotherapy
403	Pathology-Anatomic	611	Pediatric Hematology	814	Surgical Practice without operative treatment
407	Pathology-Forensic	612	Pediatric Hematology/Oncology	815	Thoracic Surgery
404	Pathology-General	613	Pediatric Infectious Diseases	818	Transplant Surgery
405	Pathology-Hematological	604	Pediatric Nephrology	816	Urology
406	Pathology-Neurological	605	Pediatric Neurology	817	Vascular Surgery
		608	Pediatric Oncology		
	MEDICINE	609	Pediatric Orthopedics		**OTHER**
301	Allergy	614	Pediatric Respiratory Medicine	901	Acupuncture
302	Cardiology	934	Pediatric Rheumatology	911	Addiction Medicine
303	Clinical Immunology	606	Pediatric Surgery	902	Administrative Medicine
304	Clinical Pharmacology			912	Aviation Medicine
305	Critical Care Medicine		**PSYCHIATRY**	908	Clinical Fellow-with moonlighting
306	Dermatology	910	Child and Adolescent Psychiatry	907	Clinical Fellow-without moonlighting
307	Emergency Medicine	321	Psychiatry	903	Community Medicine (Public Health)
308	Endocrinology	926	Psychoanalysis	915	Complementary Medicine
309	Gastroenterology	905	Psychotherapy	929	Consultations
310	Genetics			925	Coroner
311	Geriatric Medicine		**RADIOLOGY**	918	EEG
312	Hematology	704	CT (computed tomography)	919	EMG
324	Hepatology	701	Diagnostic Imaging	913	Hyperbaric/Diving Medicine
313	Infectious Diseases	705	Interventional Radiology	928	Locum
314	Internal Medicine	703	MRI	924	Managing practice (dealing with office staff, other business aspects of practice)
315	Medical Oncology	702	Therapeutic Radiology/Radiation Oncology	904	Palliative care
316	Nephrology			923	Research
317	Neurology			914	Sleep Medicine
318	Nuclear Medicine			920	Spirometry
319	Occupational Medicine			906	Sport Medicine
320	Physical Medicine and Rehabilitation			922	Teaching
322	Respiratory Medicine			930	Travel & Tropical Medicine
323	Rheumatology				

8. Please list at least 5-10 of the most common **conditions/diseases** that you CURRENTLY see in your practice as well as those you expect to see in your PROPOSED practice:

CURRENT PRACTICE (Most Common Conditions/Diseases/Procedures)	PROPOSED PRACTICE (Most Common Conditions/Diseases/Procedures)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.

Please list 5 of the most common **procedures** that you CURRENTLY perform in your practice as well as those you expect to perform in your PROPOSED practice:

FORMER PRACTICE (Most Common Procedures)	PROPOSED PRACTICE (Most Common Procedures)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

9. a) Within the past 3 years, have you undergone formal training in your **proposed** practice area? **YES** ◯ **NO** ◯

b) Within the past 3 years, what proportion of your current practice includes the same types of patients (i.e. same conditions, treatments and/or procedures) that you will care for in your **proposed** new area of practice? _____ %

c) In your **proposed** scope of practice, will you be practising within a hospital or group practice setting? **YES** ◉ **NO** ◯

d) In your **proposed** scope of practice, will you be caring for a similar or a fewer number of patients per week on average as you do in your current type of practice? **YES** ◯ **NO** ◯

PART III: TELL US ABOUT YOUR CONTINUING PROFESSIONAL DEVELOPMENT AND CONTINUING MEDICAL EDUCATION

1. If you have completed or plan to complete any formal training or educational enhancement (e.g. courses, seminars, etc.) in preparation for your proposed "scope of practice", **please describe your completed or proposed training in detail, including: content, duration and location of the training. Limited space is provided below; however, please feel free to attach any applicable information to this application**.

_____

_____

_____

_____

_____

_____

_____

Question 2 provides information about the type of professional development activities in which you participated in the past 12 months and the amount of time spent within each activity.

2. a) Regardless of your certification or membership status with the RCPSC or the CFPC do you voluntarily fulfil their professional development requirements?

YES ◉ **NO** ○ **UNSURE** ○

b) Please estimate how many hours you spent in the following formal CPD activities in the past 12 months:

RCPSC/CCFP accredited courses, conferences and workshops	10 - 20hrs
Internet based CPD activities (e.g. on-line journals, guidelines, etc)	10-20hrs
Practice-based small group learning sessions (PBSGL)	40+hrs
Self-directed learning programs	40+hrs
Hospital Committees	40+hrs
Hospital educational rounds/sessions	40+hrs
Reading journals	40+hrs
Other courses, conferences and workshops	40+hrs
Other *(Please describe below)*	

_____

_____

I certify that the information provided on this application is correct and complete to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____

Version: May 2016