APPLICATION FOR RE-ENTERING CLINICAL PRACTICE

Dear Applicant,

The College is pleased to provide you with an application package to apply to re-enter clinical practice under the College's Re-entering 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 by the College before you begin.**

Re-entering clinical 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:

- Re-Entering Practice Process and Timelines
- List of Requirements
    - please note that if you are also changing the scope of your practice there may be additional requirements listed for each of the Minimum Expectations documents, and these can be found here.
- Application Form for Physicians Re-entering Clinical Practice

Should you have any questions regarding this process, please consult our Re-entering 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 re-entering 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

RE-ENTERING 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, if you are also changing your scope of practice, 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 Re-entering Clinical Practice

The purpose of this questionnaire is to provide the College with the most current information about you and your former clinical practice, in addition to your proposed "scope of practice." You are requested to complete this application in accordance with the CPSO Policy Statement "Requirements for Re-entering Practice" approved by CPSO Council in June 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 postgraduate 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 _____

When did you last practice medicine (in any jurisdiction)?: _____

Mailing Address

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

Former Primary Practice Address *(location in which you saw 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** (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	***Fax Number***		

PART II: RE-ENTERING CLINICAL PRACTICE

1. How long have you been completely out of clinical practice?

   _____

2. Why did you choose to leave or limit clinical practice?

   _____

   _____

   _____

3. Why have you decided to return to clinical practice?

   _____

   _____

   _____

4. How did you stay current in your area of practice while you were away?

   _____

   _____

5. Will there be any significant changes to your proposed new practice compared to your former practice? Significant changes could be the location of your practice, the type of patients you are seeing and the types of problems that they have.

   a. If **YES** – Please complete **Part III**

   b. If **NO** – Please *proceed* to **Part IV**

PART III: TELL US ABOUT YOUR FORMER AND PROPOSED PRACTICE

Please complete the following sections to the best of your ability. When answering the questions below, please note that:
***Former Practice** = your former clinical activities*
***Proposed Practice** = your proposed clinical activities*
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 DID YOU WORK IN YOUR FORMER 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 worked with on a regular basis (daily/weekly) within your former office practice, as well as what you anticipate will be the situation in your proposed practice:

	FORMER		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 former office practice as well as your proposed office practice.

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

COMMUNITY SERVICES

	FORMER		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?					

WORKLOAD AND PATIENT VOLUMES

3. Please indicate in which location you saw 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.

	FORMER		**PROPOSED**	
Please complete the "former" 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 Premises (OHP)				
F. Government Facility (jail, military, etc.)				
G. House Call Service				
H. Other (please specify)_____				

CLINICAL ACTIVITY

6. Please describe your FORMER and PROPOSED clinical practice **using the table of codes listed on page 7**. 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.

FORMER – What were you **formerly** 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 **FORMER** 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.*

FORMER - 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 %**

Describe your proposed scope of practice. How will it differ from your former practice?

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. Please list 10 of the most common **conditions/diseases** that you FORMERLY saw/did in your practice as well as those you expect to see/do in your PROPOSED practice:

FORMER PRACTICE (Most Common Conditions/Diseases)	PROPOSED PRACTICE (Most Common Conditions/Diseases)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

Please list 5 of the most common **procedures** that you FORMERLY performed 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.

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

	ANESTHESIA		**OBSTETRICS AND GYNECOLOGY**		**SURGERY**
101	Anesthesia	501	Gynecologic Oncology	803	Cardiovascular Surgery
103	Chronic Pain Management with anesthesia	502	Gynecologic Reproductive Endocrinology & Fertility	804	Clinical Associates-Surgical
102	Chronic Pain Management without general/spinal anesthesia	503	Gynecologic Surgery without labour and delivery	805	Colorectal Surgery
		504	Gynecology	806	Cosmetic Surgery
		508	Maternal Fetal Medicine	820	Endoscopy
	GENERAL/FAMILY PRACTICE	505	Obstetrical Practice without labour and delivery	807	General Surgery
917	Episodic Care/Urgent Care/Walk-in	506	Obstetrics	808	General Surgical Oncology
201	General/Family Practice	507	Office Gynecology	801	Laser Surgery
202	General/Family Practice without Hospital privileges		**PEDIATRICS**	822	Laser Vision Correction
203	General Practice Oncology	617	Adolescent Medicine	809	Neurosurgery
927	Hospitalist	618	Developmental Pediatrics	821	Office Orthopedics
921	House Calls	601	Neonatology	810	Ophthalmology
916	Long Term Care/Nursing Homes	607	Pediatric Allergy/Clinical Immunology	811	Orthopedic Surgery
		603	Pediatric Cardiology	812	Otolaryngology
		619	Pediatric Clinical Pharmacology	813	Plastic Surgery
	LABORATORY MEDICINE	620	Pediatric Critical Care Medicine	819	Sclerotherapy
401	Medical Biochemistry	621	Pediatric Emergency Medicine	802	Surgical Assist
402	Medical Microbiology	933	Pediatric Endocrinology	814	Surgical Practice without operative treatment
403	Pathology-Anatomic	610	Pediatric Gastroenterology	815	Thoracic Surgery
407	Pathology-Forensic	615	Pediatric Gynecology	818	Transplant Surgery
404	Pathology-General	611	Pediatric Hematology	816	Urology
405	Pathology-Hematological	612	Pediatric Hematology/Oncology	817	Vascular Surgery
406	Pathology-Neurological	613	Pediatric Infectious Diseases	823	Surgical Opthamology
	MEDICINE	604	Pediatric Nephrology		**OTHER**
301	Allergy	605	Pediatric Neurology	901	Acupuncture
302	Cardiology	608	Pediatric Oncology	911	Addiction Medicine
303	Clinical Immunology	609	Pediatric Orthopedics	902	Administrative Medicine
304	Clinical Pharmacology	614	Pediatric Respiratory Medicine	912	Aviation Medicine
305	Critical Care Medicine	934	Pediatric Rheumatology	908	Clinical Fellow-with moonlighting
306	Dermatology	616	Pediatric Sleep Medicine	907	Clinical Fellow-without moonlighting
307	Emergency Medicine	606	Pediatric Surgery	936	Community Medicine (non-Public Health Practice)
308	Endocrinology	602	Pediatrics	903	Community Medicine (Public Health)
309	Gastroenterology		**PSYCHIATRY**	915	Complementary Medicine
310	Genetics	910	Child and Adolescent Psychiatry	929	Consultations
311	Geriatric Medicine	937	Forensic Psychiatry	925	Coroner
325	General Practice Oncology	935	Geriatric Psychiatry	918	EEG
312	Hematology	321	Psychiatry	919	EMG
324	Hepatology	926	Psychoanalysis	913	Hyperbaric/Diving Medicine
313	Infectious Diseases	905	Psychotherapy	939	Independent Medical Examinations
314	Internal Medicine		**RADIOLOGY**	928	Locum
315	Medical Oncology	704	CT (computed tomography)	924	Managing practice (dealing with office staff, other business aspects of practice)
316	Nephrology	701	Diagnostic Imaging	904	Palliative care
317	Neurology	705	Interventional Radiology	923	Research
319	Occupational Medicine	703	MRI	914	Sleep Medicine
320	Physical Medicine and Rehabilitation	708	Neuroradiology	906	Sport Medicine
322	Respiratory Medicine	318	Nuclear Medicine	922	Teaching
323	Rheumatology	707	Position Emission Tomography (PET)	930	Travel & Tropical Medicine
920	Spirometry	702	Therapeutic Radiology/Radiation Oncology	938	Other
940	Transfusion Medicine			931	Cosmetics-Non Surgical Procedures

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, location of the training, and any accredited certification. Limited space is provided below; however, please feel free to attach any applicable information to this application**.

_____

_____

_____

_____

_____

_____

_____

PART IV: RE-ENTRY PROCESS

As part of your re-entry to clinical practice, you will need to undergo a period of graded supervision, followed by a College-directed assessment of your abilities. You need to recruit one or more clinical supervisors to assist you in returning to practice. It is advisable to have more than one clinical supervisor. Your graded return to practice will take place in three phases: High Supervision, Moderate Supervision and Low Supervision

Your proposed clinical supervisor(s) must be acceptable to the College. For characteristics of an acceptable supervisor, please see the College document entitled *Guidelines for College-Directed Supervision*

Phase I – High Supervision

During this phase you will work in your supervisor(s) practice, seeing his/her patients and you will not be the MRP (Most Responsible Physician). This is analogous to a residency. You will review every patient with a supervisor before a management plan is put in place. The duration of this phase will be determined by the supervisor(s) and the College. When they feel you are ready to practice at a lower level of supervision, they will inform the College and a decision will be made to allow you to enter Phase II

Name(s) of proposed supervisor(s) (name or TBD) _____

Practice Address _____

Proposed date to begin supervision _____

Phase II – Moderate Supervision

During phase II, you become the MRP. However at all times a supervisor is immediately available, generally on site, to assist you if you have difficulty. This phase generally lasts a minimum of three months, but may be longer at the discretion of your supervisor(s) and the College.

Name(s) of proposed supervisor(s) (name or TBD) _____

Practice Address _____

Phase III – Low Supervision

During this phase you are the MRP, working independently, with your supervisor(s) reviewing your work on a regular (generally monthly) basis. Your supervisor(s) are available to assist you if needed, but not on site. This phase generally lasts six months, but may be longer at the discretion of your supervisor(s) and the College.

Name(s) of proposed supervisor(s) (name or TBD) _____

Practice Address _____

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

SIGNATURE: _____ **DATE:** _____