The College of Physicians and Surgeons of Ontario

# Supervision Arrangement

**Introduction**

*Clinical Supervision* is a form of supervision that involves the oversight and ongoing assessment of a physician's practice to ensure that the physician is meeting the expected standard of care and that patient safety is not being compromised. This form of supervision also commonly has a significant educational component for the physician being supervised.
A *Clinical Supervisor* is a physician who oversees another physician's practice to ensure that s/he is meeting the expected standard of care and that patient safety is not being compromised. The Clinical Supervisor may also take on an educational role for the physician being supervised.

**The College's criteria for the approval of a clinical supervisor include the following:**

- The proposed supervisor must not currently be the subject of any disciplinary or incapacity proceeding;
- An Ontario certificate of registration for independent practice and currently practicing in Ontario;
- A minimum of five years of consecutive independent practice in the scope of practice to be supervised (three of which must have been in Ontario);
- Member's investigation and assessment history with the College is acceptable;
- Not the subject of an active College investigation or assessment that raises concerns for the College;
- Practices at the same site as the physician to be supervised;
- Not currently supervising another physician;
- Not involved in activities that would compromise their ability to be a supervisor;
- Sufficient time and resources necessary to take on the responsibility of supervising a physician and to fulfill all terms of the College undertaking;
- Ability to provide constructive and objective feedback;
- Experience in, or willingness to learn about, the education and evaluation of practising physicians;
- Affiliations with relevant institutions in the community of practice; and
- A strong sense of professional responsibility and commitment to peer support.
- Meets the College regulation regarding CPD reporting;
- In addition to the above, the College also considers relationships that could exist between the Clinical Supervisor and supervised physician

**NOTE: This form must be completed by the supervisor(s) and applicant as indicated.**

## SECTION A

### INFORMATION PERTAINING TO THE SUPERVISED PHYSICIAN

**TO BE COMPLETED BY SUPERVISOR**

| | | | |
|---|---|---|---|
| Applicant's Surname | | | |
| Applicant's Given Name | | | |
| CPSO / Reference Number *(If known)* | | Applicant's Email Address | |
| Specialty Certification | | | |
| Current Scope of Practice | | | |
| **Proposed Practice Location(s):** *Please list all practice address(es). If practicing at more than one location, indicate the primary practice site.* | | | |
| | | | |

### INFORMATION PERTAINING TO THE SUPERVISOR

**PLEASE ATTACH A COPY OF YOUR CURRENT CURRICULUM VITAE**

| | | | |
|---|---|---|---|
| Supervisor's Surname | | | |
| Supervisor's Given Name | | | |
| CPSO Number | | Supervisor's Email Address | |
| Specialty Certification | | | |
| Current Scope of Practice | | | |
| **Current Practice Location(s):** *Please list all practice address(es). If practicing at more than one location, indicate the primary practice site.* | | | |
| | | | |

| | | |
|---|---|---|
| Have you met with Dr. | | |
| and reviewed his/her curriculum vitae? | | Yes ☐ No ☐ |
| *If "No", please explain on a separate sheet when you intend to meet the supervised physician.* | | |
| Are you related to Dr. | | |
| in any way or is there any reason why you cannot be objective in your supervision of | | |
| Dr. | | Yes ☐ No ☐ |
| *If "Yes", please explain on a separate sheet.* | | |
| To your knowledge, are you currently subject of an investigation with the CPSO? | | Yes ☐ No ☐ |

## SECTION B

### DETAILS OF THE SUPERVISION ARRANGEMENT

The Clinical Supervision plan should include details of: the duties and responsibilities of the physician, how and when the Clinical Supervision will be conducted, what level of autonomy the candidate will have, who will be the Most Responsible Physician (MRP) for the care provided, the availability of the Clinical Supervisor, identification of a back-up Clinical Supervisor, the frequency with which the physician will be conducting chart reviews, and the minimum number of charts that will be reviewed. The Clinical Supervisor's curriculum vitae should also be included with the Clinical Supervision plan.

**TO BE COMPLETED BY SUPERVISOR**

Please provide details of the supervision arrangement, including how you intend to incorporate the following tools which are commonly used to verify that the patient care provided by the supervised physician meets the standard of care:

1. Direct observation of patient care where appropriate.
2. Review of patient charts on a regular basis and discussion of any concerns arising;
3. Feedback from other members of staff;
4. Make recommendations for practice improvements and on-going professional development.

The detailed explanation should include at a minimum the following components in order for the supervision arrangement to be meaningful and to ascertain the quality of care provided by you:

- Details of your responsibilities (your scope of practice, all practice sites where you are expected to practice); and
- How the supervision would be provided (i.e. would the supervisor be available on site at all times, sometime or never; how the supervision would be carried out).

*Please attach a separate sheet if needed.*

| | | | |
|---|---|---|---|
| I will conduct chart reviews of the practice of: | | | |
| Dr.: | | Yes ☐ | No ☐ |
| Please indicate how often you will conduct chart reviews. At a minimum, the Registration Committee will expect you to review 10 charts every two weeks for the first month, and 10 charts per month thereafter. | | | |
| | | | |
| I will provide a formal orientation of the practice site. | | Yes ☐ | No ☐ |
| I will familiarize myself with the site should I not practice at this location. | | Yes ☐ | No ☐ |
| Will the supervised physician be responsible for the training of medical students, post graduate trainees or clinical fellows? | | Yes ☐ | No ☐ |
| If 'yes', please explain the arrangement | | | |
| | | | |
| I will provide regular reports to the College regarding the progress of: | | | |
| Dr. | | | |
| every 6 months or more frequently if directed by the Registration Committee. | | Yes ☐ | No ☐ |
| The Registration Committee expects you to make arrangements in the event of your absence (i.e. vacation, leave, and unexpected absence). Please identify a physician who is able to provide back-up supervision of the supervised physician in the event of your absence: | | | |
| Dr. | | CPSO Number | |

**PROPOSED CLINICAL ACTIVITY**

1. Every physician's scope of practice is unique.
2. A physician's scope of practice is determined by the patients the physician cares for, the procedures performed, the treatments provided, and the practice environment.
3. A physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgment, which are developed through training and experience in that scope of practice.

## Most Common/Diseases/Procedures

Please list the 10 most common Conditions/Diseases/Procedures that supervised physician will see/perform in their practice.

| |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |

## ACKNOWLEDGEMENT

**TO BE COMPLETED BY SUPERVISOR**

a) I certify that the information provided on this form is correct and complete.
b) I confirm that I have read and understand the Guidelines for College-Directed Supervision.

***Please complete the necessary fields below electronically, print and add all signatures before returning to the College.***

| | | | |
|---|---|---|---|
| Name | | | |
| Signature | | Date | |

**TO BE COMPLETED BY BACK-UP SUPERVISOR**

| | | | |
|---|---|---|---|
| a) I agree to provide back-up supervision to Dr. | | | |
| in the absence of Dr. | | | |
| b) I agree to report any concerns relating to Dr. | | | 's practice |
| to Dr. | | and the College. | |
| Name | | | |
| Signature | | Date | |

**TO BE COMPLETED BY APPLICANT**

a) I confirm that I have read the supervision plan detailed above.
b) I certify that the information provided on this form is correct and complete.
c) I confirm that I have read and understand the Guidelines for College-Directed Supervision

| | | | |
|---|---|---|---|
| Name | | | |
| Signature | | Date | |

## SECTION C

**TO BE COMPLETED BY APPLICANT**

*Please complete this section only if you are applying for a certificate of registration under a policy that requires an assessment of your practice, i.e. Pathways, Acceptable Qualifying Examination, Alternative to MCCQE2, CFPC Certification without Examination.*

| | |
|---|---|
| Please be advised that the Registration Committee will make a decision about granting a subsequent certificate of registration if the requirements prescribed on your certificate of registration have been satisfactorily completed and it has considered the report pertaining to the assessment of your practice.<br><br>**Upon successful completion of a practice assessment, you will be issued a Restricted certificate of registration to practice medicine limited to the scope of practice that was assessed.** | |
| After the completion of a practice assessment, do you intend to engage in the same type of practice in Ontario as described in your supervision plan? | Yes ☐ No ☐ |
| Please indicate the scope of practice that you expect to be reflected on your certificate of registration upon the successful completion of a practice assessment. | |
| | |

Please note that if your scope is family medicine, your supervised practice must include continuity of care (practicing primarily in a walk-in setting would not meet this criteria)

## RESOURCES

To review **the College's Guidelines for College-Directed Supervision**, and for details relating to eligibility criteria for supervisors, visit our website at **www.cpso.on.ca**, follow the **Registration** link from the home page, then select **Registration Policies**. Frequently Asked Questions relating to Registration Assessment is also available on the same page.

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**Please complete this form electronically, print out, add signatures and return to:**

Applications and Credentials Department
College of Physicians and Surgeons of Ontario
80 College Street, Toronto, ON M5G 2E2

**Fax:** 416-967-2619

**Email:** regcomm@cpso.on.ca