

# Quality Assurance Committee

## Application Form for Physicians who HAVE ALREADY CHANGED their “Scope of Practice”



The purpose of this questionnaire is to provide the Quality Assurance Committee (QAC) with the most current information about your changed “scope of practice” and about your former practice. You are requested to complete this application in accordance with the CPSO policy *Changing Scope of Practice* approved by CPSO Council in April 2008. The information you provide will be reviewed by the QAC and/or by staff who support the QAC.

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 the QAC and its related programs will be in aggregate, unidentifiable formats.

**PLEASE PRINT LEGIBLY USING BLACK INK ONLY**

|   |  |                  |
|---|--|------------------|
| SURNAME (as given on CPSO register): _____  |  |                  |
| GIVEN NAME(S)(as given 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 <input type="radio"/> No <input type="radio"/> Year _____ Member Yes <input type="radio"/> No <input type="radio"/> |  |                  |
| Royal College of Physicians and Surgeons of Canada: Fellowship Yes <input type="radio"/> No <input type="radio"/> Year _____ Specialty _____                                |  |                  |
| List of hospitals with which you are affiliated:  | Admitting Privileges                               |                  |
| _____   | Yes <input type="radio"/> No <input type="radio"/> |                  |
| _____   | Yes <input type="radio"/> No <input type="radio"/> |                  |

### 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    |

**Current Secondary Practice Address (if applicable)**

|   |  |                 |  |                          |  |                         |  |
|---|--|-----------------|--|--------------------------|--|-------------------------|--|
| <i>Hospital/Facility Name (if applicable)</i> |  |                 |  | <i>Street and Number</i> |  | <i>Suite Number</i>     |  |
| <i>City</i>                                   |  | <i>Province</i> |  | <i>Postal Code</i>       |  | <i>Office Telephone</i> |  |

**PART I: WHERE WAS YOUR FORMER PRACTICE LOCATION?**

**Former Practice Address (if different from current location -- location where you formerly practised)**

|   |  |                 |  |                          |  |                         |  |
|---|--|-----------------|--|--------------------------|--|-------------------------|--|
| <i>Hospital/Facility Name (if applicable)</i> |  |                 |  | <i>Street and Number</i> |  | <i>Suite Number</i>     |  |
| <i>City</i>                                   |  | <i>Province</i> |  | <i>Postal Code</i>       |  | <i>Office Telephone</i> |  |
| <i>Email Address</i>                          |  |                 |  |                          |  |                         |  |

**When did you change your “scope of practice”?** \_\_\_\_\_

**PART II: TELL US ABOUT YOUR FORMER AND CURRENT PRACTICE STRUCTURE**

*Please complete the following sections to the best of your ability. When answering the questions below, please note that:*  
**Current Practice** = your new scope of practice plus any clinical activities that you continue to do from your former practice  
**Former Practice** = your clinical activities before you changed your “scope of practice”

**WITH WHOM DID YOU WORK IN YOUR FORMER OFFICE PRACTICE AND WITH WHOM DO YOU WORK IN YOUR CURRENT PRACTICE?**

1. Please indicate the number of full-time and part-time personnel that you formerly worked with, as well as the personnel you currently work with on a regular basis (daily/weekly) within your office practice:

|                                 | FORMER |     | CURRENT |     |
|---------------------------------|--------|-----|---------|-----|
|                                 | # FT   | #PT | #FT     | #PT |
| <b>FOR OFFICE PRACTICE</b>      |        |     |         |     |
| Physicians                      |        |     |         |     |
| Registered Nurses (RNs)         |        |     |         |     |
| Nurse Practitioners (NPs)       |        |     |         |     |
| Administrative Staff            |        |     |         |     |
| Other (please specify)<br>_____ |        |     |         |     |

2. Tell us what you share(d) with other physicians in your former office practice as well as your current office practice.

| FOR OFFICE PRACTICE | FORMER                |                       | CURRENT               |                       |
|---------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|                     | YES                   | NO                    | YES                   | NO                    |
| Staff               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Office space        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Patient Records     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**TELL US ABOUT WHERE YOU FORMERLY WORKED AND WHERE YOU WORK NOW**

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 you spent during direct patient contact in your *former* practice setting.

| Please complete the “former” and “current” columns for <u>only</u> those facilities that apply.  | FORMER          |                                       | CURRENT                                |  |
|--|-----------------|---------------------------------------|--|--|
|  | # patients seen | # hrs spent in direct patient contact | Approx. # patients expected to be seen | Approx # hrs to be spent in direct patient contact |
| <b>Facility</b>  |                 |                                       |  |  |
| <b>A. Office Practice:</b>   |                 |                                       |  |  |
| 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>B. Hospital:</b>  |                 |                                       |  |  |
| a) Community Hospital  |                 |                                       |  |  |
| > Inpatients   |                 |                                       |  |  |
| > Outpatients  |                 |                                       |  |  |
| > Emergency  |                 |                                       |  |  |
| > Surgical Assist  |                 |                                       |  |  |
| > Day Surgery  |                 |                                       |  |  |
| > Hospitalist  |                 |                                       |  |  |
| b) Academic/Teaching Hospital  |                 |                                       |  |  |
| > Inpatients   |                 |                                       |  |  |
| > Outpatients  |                 |                                       |  |  |
| > Emergency  |                 |                                       |  |  |
| > Surgical Assist  |                 |                                       |  |  |
| > Day Surgery  |                 |                                       |  |  |
| > Hospitalist  |                 |                                       |  |  |
| <b>C. Long-Term Care Facility/Nursing Home etc.</b>  |                 |                                       |  |  |
| <b>D. Independent Health Facility (IHF)/Diagnostic or Procedural Out of Hospital Facilities (Non-IHF)</b>                                      |                 |                                       |  |  |
| <b>E. Government Facility (jail, military, etc.)</b>   |                 |                                       |  |  |
| <b>F. House Call Service</b>   |                 |                                       |  |  |
| <b>G. Other (please specify) _____</b>   |                 |                                       |  |  |



## CLINICAL ACTIVITY

6. Please describe your FORMER and CURRENT 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.

**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 |         |          |          |          |          |       |

**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 |         |          |          |          |          |       |

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 fall within your CURRENT practice (right column).  
*Please note that the total should equal 100 percent.*

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

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

|     | <b>ANESTHESIA</b>   |     | <b>OBSTETRICS AND GYNECOLOGY</b>                   |     | <b>SURGERY</b>  |
|-----|---|-----|--|-----|---|
| 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  |
|     | <b>GENERAL/FAMILY PRACTICE</b>                                    | 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               |     | <b>PEDIATRICS</b>                                  | 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  |
|     | <b>LABORATORY MEDICINE</b>  | 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                                 |     |   |
|     | <b>MEDICINE</b>   | 609 | Pediatric Orthopedics                              |     | <b>OTHER</b>  |
| 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  |     | <b>PSYCHIATRY</b>                                  | 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  |     | <b>RADIOLOGY</b>                                   | 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/procedures that you FORMERLY saw/did in your practice, as well as those you see/do in your CURRENT practice:

| FORMER PRACTICE<br>(Most Common Conditions/Diseases/Procedures) | CURRENT PRACTICE<br>(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.  |

9. a) What proportion of your former practice included the same types of patients (i.e. same conditions, treatments and/or procedures) that you care for in your **current** practice? \_\_\_\_\_ %
- b) In your **current** “scope of practice”, do you care for a similar or a fewer number of patients per week on average as you did in your former type of practice?
- Yes
- No

10. Please tell us about your medical records in your **current** area of practice:

- a) Which best describe your **current** records:
- Electronic medical/clinical/patient records  
Please specify the software/vendor \_\_\_\_\_
- Hand written records
- Hospital records only

- b) Are your complete medical records located in your office?
- Yes
- No

- c) If not, please indicate and describe where and how you obtain your patients’ complete medical record.

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- d) Language of records:
- English
- French

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

1. Have you undergone formal training for your **changed** “scope of practice”? **YES** **NO**
2. If you answered “yes” to having undergone formal training and educational enhancement (e.g. courses, seminars, etc.) for your changed “scope of practice”, **please describe your 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.**

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Question 3 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.

3. 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 CME activities in the past 12 months:

|  | <b>0 - 10hrs</b>      | <b>10 - 20hrs</b>     | <b>20 - 30hrs</b>     | <b>30 - 40hrs</b>     | <b>40+ Hrs</b>        |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| RCPSC/CCFP accredited courses, conferences and workshops               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Internet based CME activities (e.g. on-line journals, guidelines, etc) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Practice-based small group learning sessions (PBSGL)                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Self-directed learning programs  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hospital Committees  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hospital educational rounds/sessions                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Reading journals   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other courses, conferences and workshops                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other ( <i>Please describe below</i> )                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_