

# Quality Assurance Committee

## Application Form for Physicians PROPOSING TO CHANGE their “Scope of Practice”



The purpose of this questionnaire is to provide the Quality Assurance Committee (QAC) 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 *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: Certificiant 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					

**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)

<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>Email Address</i>
<i>Office Telephone</i>	<i>Home Telephone</i>	<i>Fax Number</i>	

**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		Unknown
	# FT	#PT	#FT	#PT	
<b>FOR OFFICE PRACTICE</b>					
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	<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 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.

Please complete the “current” and “proposed” columns for <u>only</u> those facilities that apply.	CURRENT		PROPOSED	
	# 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”)
<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 **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.*

<b>CURRENT</b> - Percent of patient visits	<b>Category</b>	<b>PROPOSED</b> – Percent of patients you anticipate in each area
	<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 CURRENTLY see/do in your practice as well as those you expect to see/do 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.

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 and 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.**

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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 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"/>

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

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

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