Change of Scope and Re-entering Practice (COSRE) Information Sheet

Submission of COSRE application and updated Curriculum Vitae

→ Please allow for 3 days to process your application which will then be available to you by logging into the Member Portal. You can check for updates, outstanding requirements, and receipt of documents.

→ Processing time is usually 3 – 4 weeks from receipt to completion of needs assessment.

↓ If Registration Committee review is required more time will be needed. Please review "Registration Committee" web page for more information.

← You will be advised of the outcome of the review and of next steps, if required.

← You may not begin practising in a new clinical scope or return to practice until the College has approved you to do so.

Having issues logging into Member Portal or uploading documents? Contact Inquiries at 416-967-2617 or inquiries@cpso.on.ca

CPSO

TRUSTED DOCTORS PROVIDING GREAT CARE

If you need to connect directly with COSRE staff please contact us at cosre@cpso.on.ca

College of Physicians and Surgeons of Ontario

Changing Scope of Practice Form

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 "Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice" approved by CPSO Council in February 2018. The information you provide will be reviewed by the staff who support the Changing Scope of 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):** / /

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: Year: Enhanced Skills Program:

Royal College of Physicians and Surgeons of Canada:

Year: Specialty: Subspecialty:

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 *Preferred Phone 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 *Preferred Phone Number*

What is your current scope of practice?

What is/are your proposed change in scope of practice?

Will you be changing your practice address if so, please give location and name of facility.

Hospital/Facility Name (if applicable)

Street and Number

Suite Number

City

Province

Postal Code

Email Address

Office Telephone

Preferred Phone Number

What educational steps have you taken/do you propose to enable your change of scope?

What resources (clinical supervisors/colleagues/facility/ancillary) will be available to support your change?

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

Signature:

Date: