## APPLICANT INFORMATION

Name: _____ CPSID: _____

Address: _____

City: _____ Province/state: _____

Postal code/zip code: _____ Country: _____

Telephone: _____ Email: _____

Proposed start date: _____

Specialties: _____

## MSP RESTRICTED SERVICES AND FACILITY INFORMATION

Facility name: _____ Facility ID: _____

Address: _____

City: _____ Province/state: _____

Postal code/zip code: _____ Country: _____

Telephone: _____ Email: _____

Submission date: _____

Indicate each restricted service requested. Refer to the BC MQI Provincial Privileging Dictionaries for requirements.

Restricted service: _____ Restricted service: _____

Restricted service: _____ Restricted service: _____

## MEDICAL DIRECTOR APPROVAL

I certify that I am satisfied that, with respect to the MSP restricted services applied for above, this physician applicant:

- meets all the requirements as outlined in the relevant BC MQI Provincial Privileging Dictionaries;
- is current for practice in the relevant area of medicine; and
- has performed a sufficient volume of services in the last three years for me to recommend credentialing in my clinic.

Medical director name: _____ CPSID: _____

Signature: _____ Date: _____

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