Hospital Medical/Surgical Facility
PODIATRIST

FACILITY INFORMATION

Facility name: ______________________ NHID: __________

Submission date: ______________ Requested start date: ______________

PERSONAL INFORMATION

First name: ______________ Middle name: ______________

Last name: ______________ Practitioner type: ______________

BUSINESS CONTACT INFORMATION

Notes: ______

BC LICENSURE

Type of licence: ______

Licence status: ______ Name of BC college: ______

Number: ______ Field of licensure: ______

PROFESSIONAL LIABILITY PROTECTION

Insurance provider: ◯ CMPA ◯ MPP ◯ CDSPI ◯ ENCON ◯ Other: ______

Plan/membership number: ______ Code: ______ MSP billing number: ______

Effective date: ______ Expiry date: ______

APPOINTMENT

Medical staff category requested (at non-hospital facility):

◯ Provisional (new medical staff to first year on staff)
◯ Temporary (defined time period and/or specified number of cases) End date: ______

Discipline: ______ Discipline sub-specialty: ______

Current and previous restrictions to license or scope of practice (voluntary, self-imposed, imposed):

______

APPROPRIATE PROCEDURES LIST

An appropriate procedures list indicating only the procedures you are applying to perform at the above facility must be submitted with the application (refer to the BC MQI Provincial Privileging Dictionaries for core procedures in your area of practice.

☐ With respect to the list of procedures for which you seek approval, you acknowledge awareness of the requirement in section 2-2(3) of the Bylaws which states: A registrant must practise medicine within the scope of his or her training and recent experience and must not engage in a medical practice that he or she is not competent to perform. The failure to comply with this requirement may result in a finding of unprofessional conduct.

◯ Appropriate procedures list attached
◯ N/A

CERTIFICATE OF PROFESSIONAL CONDUCT

I have requested for the College to release to the medical director a current Certificate of Professional Conduct (https://www.cpsbc.ca/files/pdf/Registration-Consent-for-CPC.pdf).

◯ Consent for Certificate of Professional Conduct sent to cpc@cpsbc.ca
◯ N/A

REFERENCES

Nametwo professional referees with whom you have worked within the last three years. One must be the head of hospital department or division or senior medical administrator of the organization in which you most recently w or the program director, if you have recently completed postgraduate training.

Applicants requesting privileges/practice activities requiring special skills must include at least one reference spe addressing recent training and/or experience in these areas.

References must have current knowledge of the individual and their practice. Each referee must complete the Re for Applicants for Privileges at Non-Hospital Medical/Surgical Facility form.

Additional references may be requested.

Chief of staff/senior medical administrator/program director

____

TRAINING

Program type: ____________________ Degree/diploma: ____________________

Institution name: ____________________

City: ____________________ Country: ____________________

From: ____________________ To: ____________________

Program type: ____________________ Degree/diploma: ____________________

Institution name: ____________________

City: ____________________ Country: ____________________

From: ____________________ To: ____________________

Program type: ____________________ Degree/diploma: ____________________

Institution name: ____________________

City: ____________________ Country: ____________________

From: ____________________ To: ____________________

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Society: ____________________ From: __________ To: __________

Society: ____________________ From: __________ To: __________

Society: ____________________ From: __________ To: __________

OTHER TRAINING SKILLS/CERTIFICATION

BLS (HCP or equivalent), ACLS, PALS, difficult airway course, laser training, radiation safety training, diplomas in a skills, etc.

Online BLS and ACLS certification and recertification courses without a classroom hands-on component led by a instructor are not accepted. Please note that BLS and ACLS certification are valid for two years from date of iss

Please provide a copy of all training documentation.

Course	Date issued	Attached
BLS (mandatory)	__________	☐
____________________	__________	☐
____________________	__________	☐

CURRENT REGISTRATIONS/LICENSES IN OTHER JURISDICTIONS

Jurisdiction: __________ Specialty: __________ From: __________ To: __________

Jurisdiction: __________ Specialty: __________ From: __________ To: __________

From: ________ To: ________ Position: ________

Reason for leaving: ________

Hospital/non-hospital/organization: ________

City: ________ Province/state: ________ Country: ________

From: ________ To: ________ Position: ________

Reason for leaving: ________

DECLARATION FOR APPOINTMENT TO THE MEDICAL STAFF

1. Professional liability coverage or protection

I declare that:

APPLICANT ACKNOWLEDGEMENT AND CONSENT

I understand and agree that I have the burden of providing adequate information for the proper evaluation of my professional competence, character, ethics, qualifications, licensure, insurance and other qualifications and for responding to any inquiries about such information to the satisfaction of the non-hospital facility medical directo

I am a registrant in good standing with my professional College.

I agree to:

- abide by the Code of Ethics and Professionalism as adopted by my professional College at all times during my appointment to the medical staff.
- maintain and provide proof of professional liability insurance protection appropriate to my professional activit within the non-hospital facility.
- inform the non-hospital facility medical director of any changes that would affect my ability to practice medi the type of practice I undertake while a member of the medical staff (e.g. licensure, professional liability insu coverage, my health, qualifications, immigration status).
- release the non-hospital facility, employees, agents, staff and medical staff from all liabilities and claims for lo sustained in connection with evaluating my application for medical staff membership, except where such loss caused by their gross negligence or intentional misconduct.

I acknowledge that:

- I have read the College of Physicians and Surgeons of BC Bylaws, the NHMSFAP Standards and Policies and t Medical Staff Rules of the non-hospital facility regarding professional conduct and assessment.
- if appointed to the medical staff, I will fulfill my responsibilities as a member of the medical staff, as defined College Bylaws, the NHMSFAP Standards and Policies and the Medical Staff Rules of the non-hospital facility.
- any breach of the above agreement, or any misrepresentation or material omission on my part in completing application may result in the denial, revocation or suspension of my appointment to the medical staff.

I understand that the non-hospital facility and the NHMSFAP will collect, use and disclose personal information a for the purposes of:

- evaluating my application for medical staff membership.
- administering and maintaining my medical staff membership and relationship with the non-hospital facility inc maintaining privileges/practice activities and access to information systems and equipment.
- non-hospital facility and NHMSFAP Committee planning.

I consent to the following:

- the non-hospital facility and NHMSFAP may contact the referees whose names I have provided for the purpo evaluating my application for appointment/reappointment/employment and privileges/practice activities.
- my personal information will be stored by the non-hospital facility and the NHMSFAP and may be shared with BC health authorities and their affiliates for the purposes stated above.

APPLICANT AUTHORIZATION

In signing this document:

- I acknowledge I have read and understand the points in the above declaration and acknowledgment.
- I declare that I have requested only those privileges for which by education, training and current experience, demonstrated performance I am qualified to perform and for which I wish to exercise at the non-Hospital fac am applying.
- I declare that the information submitted by me in this application is true to the best of my knowledge.

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MEDICAL DIRECTOR DECLARATION AND RECOMMENDATION FOR APPOINTMENT

In signing this document:

I acknowledge that I have reviewed this medical staff application for appointment, requested clinical privilege supporting documentation.

I acknowledge that I am responsible for notifying the Non-Hospital Medical and Surgical Facility Accreditation Program of this medical staff appointment by submitting the NHMSFAP Notification of Medical Staff Appointr Form.

I hereby:

☐ Appoint this medical staff be granted all privileges as requested on the appropriate procedures list(s)

☐ Recommend that this medical staff be granted privileges with the following conditions/modifications

☐ Do not recommend that this applicant be granted privileges

Privilege condition/modification/explanation:

Medical director signature: ______________________ Date: ______________________

NEXT STEPS

For medical directors of accredited facilities:

Maintain a copy of this form and supporting documents in the medical staff's human resources file

Notify the NHMSFAP of new staff appointments by submitting the Notification of New Medical Staff Appointment Form and appropriate procedures list(s)

See the CPSBC website for more information

For new facilities applying for accreditation:

Submit this form and supporting documents to NHMSFAP

See the CPSBC website for more information

The information in this form is collected under the authority of part 5, section A of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183. The