FACILITY INFORMATION

The medical director is required to meet annually with each member of the medical staff. This reapplication form is to be kept on file at the facility and a copy submitted to the NHMSFAP as outlined below or as requested.

Facility name: _____

NHID: _____ Date last worked at facility: _____ Renewal date: _____

APPLICANT INFORMATION

This form is to be submitted to the facility at which reapplication is being requested.

Applicant name: Website: _____

		Medical	Other
☐ ENT	☐ Orthopedic	☐ Anesthesia	☐ Dentistry
☐ Gastroenterology	☐ Pediatric	☐ Dermatology	☐ Hair transplant
☐ General	☐ Plastics	☐ Radiology	☐ Podiatry
☐ Gynecology	☐ Surgical uterine evacuation	☐ Psychiatry	☐ Surgical assist
☐ Neurosurgery	☐ Urology		☐ Other: _____
☐ Ophthalmology	☐ Vascular		

APPLICANT QUESTIONS

If the answer to any of the below questions is yes, please provide brief details in a separate letter to the medical director, unless previously submitted. The medical director must then provide a copy of this reapplication form to the Non-Hospital Medical and Surgical Facilities Accreditation Program.

1. Have you had any restrictions or modifications placed on your surgical privileges or practice by a hospital or a medical surgical facility? ◯ Yes ◯ No
2. Has there been any disciplinary action toward you for professional conduct or competence by a professional body during the previous year? ◯ Yes ◯ No
3. Have you relinquished your hospital surgical or anesthetic privileges in the past year? ◯ Yes ◯ No
4. Have you altered your scope of practice in the past year? ◯ Yes ◯ No

APPLICANT AUTHORIZATION

I hereby certify that the information provided in this application is true.

I hereby authorize the College of Physicians and Surgeons of British Columbia to make such inquiries about me as it considers appropriate in connection with this application.

I authorize the committee for the Non-Hospital Medical and Surgical Facilities Accreditation Program to revoke any privileges or approval to practise at the above-named facility if it subsequently appears that I have, by any omission or commission, given false, misleading or ambiguous information in respect of any question on this application form.

Applicant signature: _____ Date: _____

MEDICAL DIRECTOR APPROVAL

Please confirm that the following actions have been taken and appropriate documentation made and stored with the physician's record in your facility.

1. A record detailing the approximate number of each surgical procedure, or a total number general anesthetics, IV anesthetics, or regional blocks he or she performed at the facility in the previous year is attached and filed with the physician's file. ◯ Yes ◯ No
2. These surgical statistics have been forwarded to the Non-Hospital Medical and Surgical Facilities Accreditation Program administration. This may be provided in a basic table containing the statistics of all physicians at the facility. ◯ Yes ◯ No
3. A period of no longer than 12 months has elapsed since time of initial approval or last reapplication for privileges. ◯ Yes ◯