College of Physicians & Surgeons of Alberta

Physician Sponsorship

SPONSOR INSTRUCTIONS:

1. Please fully read and complete this form
2. Review the Applicant's Eligibility Letter issued by the College of Physicians & Surgeons of Alberta (CPSA)
3. Forward the completed form to the CPSA Registration at registration@cpsa.ab.ca

APPLICANT DETAILS:

Applicant's Last Name: _____ Applicant's Given Name(s): _____

CPSA tracking number: CPSA._____

Discipline the applicant is being sponsored to practice in: _____

Does the applicant's intended practice match what is outlined in the CPSA Eligibility Letter? ☐ Yes ☐ No

The applicant requires (as outlined in the applicant's CPSA Eligibility Letter):

☐ Preliminary Clinical Assessment of approximately 3 months and a Supervised Practice Assessment of approximately 3 months

☐ Supervised Practice Assessment of approximately 3 months only
Please list the names of three potential supervisors for the Supervised Practice Assessment:
NOTE: The SPA supervisor cannot have any financial interest in the facility/clinic

1. _____
2. _____
3. _____

Specify all location(s) where the applicant will practice following a successful assessment (e.g., Clinic/Hospital/Long Term Care facility name and address, solo or group practice):

Type(s) of practice they will work in: (check all that apply)

☐ Clinic/Office ☐ Walk-In Clinic ☐ Acute Care In-Patient ☐ Long Term Care In-Patient

☐ Emergency Dept. ☐ Obstetrics ☐ Anesthesia ☐ Surgery

☐ Other (specify): _____

SPONSOR DETAILS:

Sponsors are required to sign an **agreement** with the CPSA identifying both parties' responsibilities as well as the Provincial Physician Assessment Program (PPAP) fees that the sponsor is responsible for paying.

Applicant is being sponsored by Alberta Health Services Zone: _____
(Identify Zone)

Applicant is being requested by Community:

_____
(Identify Community)

Applicant is being requested by Facility:

_____
(Identify Facility)

Facility Contact Person:
(AHS Department or Community Practice)

_____
(Name)

_____
(Email)

Anticipated date Applicant is able to start the assessment: _____
(Note: This is not a guaranteed start date) (dd/mmm/yyyy)

Zone Medical Director (please print): _____ Date signed: _____

Zone Medical Director's Signature: _____

PRINT AND SIGN

Please return completed form to CPSA REGISTRATION DEPARTMENT
Email: registration@cpsa.ab.ca