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 (PCA) of approximately 3 months and a Supervised Practice Assessment of approximately 3 months

☐ Supervised Practice Assessment (SPA) of approximately 3 months only

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 or personal **conflict of interest** with the applicant. These Supervisors must be notified prior to submission that they are listed on this Form.

Potential supervisors should also work in **all locations** that the applicant needs to be supervised in (i.e. clinic/ER/long term care/acute care in patient)

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 Applicant will work in: (Check all that apply)

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

☐ Emergency Dept. ☐ Low-Risk Obstetrics ☐ Other (specify): _____

The following assessments for **General Practitioners with Special Skills** are agreed to be related to specific privileging, as deemed by the recruitment for AHS. This will be the responsibility of the respective Zone to arrange after the Preliminary Clinical Assessment, if applicable.

☐ Anesthesia

☐ Enhanced Obstetrical Surgical Skills, specify which Enhanced Obstetrical Surgical Skills: _____

SPONSOR DETAILS:

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)

_____
(Print Name)

_____
(Email)

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

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

Zone Medical Director's Signature: _____

PRINT & SIGN FORM

Please return all completed pages of this Form to
CPSA REGISTRATION DEPARTMENT
registration@cpsa.ab.ca