College of Physicians & Surgeons of Alberta

Sleep Medicine

Physician Approval Sleep Medicine Diagnostics

(Requirements for Alberta Diagnostic Sleep Medicine Facilities and Services are as per the College of Physician & Surgeons Sleep Medicine Standards Section: Appendix A)

(Check all that apply)
I am applying to be a ☐ Medical Director ☐ Interpreter ☐ Both

For the following services:

☐ Adult Comprehensive Polysomnography
☐ Adult Unattended Polysomnography
☐ Adult Complex Respiratory Patients
☐ Adult Home Sleep Apnea Testing
☐ Pediatric Comprehensive Polysomnography
☐ Pediatric Complex Respiratory Patients

APPLICANT INFORMATION (Please Print)

CPSA Registration Number: _____

Last Name: _____ Given/First Names: _____

Street Address: _____

City: _____ Postal Code: _____

Telephone Number: (_____) _____E-mail Address: _____

1. Specialty:
☐ Internal Medicine ☐ Adult Neurology ☐ Pediatric Neurology ☐ Cardiology
☐ Adult Psychiatry ☐ Otolaryngology ☐ Pediatric Respirology ☐ Respirology
☐ Family Medicine ☐ Pediatric Psychiatry ☐ Developmental Pediatrics ☐ Pediatrics

2. Qualifications in Sleep Medicine:

☐ Certification in Sleep Medicine from the American Board of Sleep Medicine
☐ Somnologist - Expert in Sleep Medicine from the European Sleep Research Society (ESRS)
☐ Other (please specify): _____

3. My training is as follows:

Institution	Dates	
	From (Month/Year)	To (Month/Year)

4. I have enclosed a letter confirming training and competence from the program provider Yes ☐ No ☐
(Note: This evidence of training and competence is required.)

5. My clinical experience is as follows:

Institution	Dates	
	From (Month/Year)	To (Month/Year)

Type/Description of Procedure	Check only those procedures for which you are requesting approval.	Total number of procedures performed in the past year. **Numbers must be provided for requests to be processed.**	
		ADULT	PEDIATRIC
A. Attended Polysomnography			
• Standard Comprehensive Polysomnogram	☐		
• Comprehensive Polysomnogram with expanded montage.	☐		
• Multiple Sleep Latency Test (MSLT)	☐		
• Maintenance of Wakefulness Test (MWT)	☐		
B. Additional Respiratory Physiologic Monitoring Polysomnography			
o Esophageal Manometry	☐		
o Quantified Oronasal Airflow	☐		
o Continuous Transcutaneous Carbon dioxide (TCO_2) Monitoring	☐		
o Arterial Blood Gas Measurement	☐		
C. Unattended Polysomnography	☐		
D. Home Sleep Apnea Testing	☐		
E. Actigraphy	☐		
F. CPAP titration	☐		
G. Bi-level PAP titration	☐		

6. **Expected Practice Start Date:** _____

Applicant Signature: _____ **Date:** _____

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7. **Documentation Submissions:**

Please sign, scan and email your completed application and documentation (together as one package) to sleep.medicine@cpsa.ab.ca