College of Physicians & Surgeons of Alberta

Diagnostic Imaging Accreditation
Facility Notification of Change

Facility Name: _____ **Facility Number:** _____

(Please check and provide the updated information only):

Change	**Details**
☐ Facility Name:	
☐ Imaging Services:	
☐ Medical Director:	
☐ Manager/Supervisor:	
☐ Address:	
☐ Phone:	
☐ Email:	
☐ Other (please specify):	

NOTES:

SIGNATURE

I have reviewed and confirm the above facility information is accurate.

Medical Director/Executive Designate Name: _____

Date: _____

Signature: _____

Please submit completed form to the College:

Diagnostic Imaging Accreditation Program
College of Physicians & Surgeons of Alberta
2700, 10020 – 100 Street NW
Edmonton, Alberta T5J 0N3
diagnostic.imaging@cpsa.ab.ca

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