College of Physicians & Surgeons of Alberta

Clinical Accreditation Services

CPSA Notification - Change to Facility

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

CHANGE TO FACILITY INFORMATION

(Please check and provide **the updated information only**):

- ☐ Facility Name: _____
- ☐ Testing/Procedures/Anesthesia: _____
- ☐ Medical Director: _____
- ☐ Full Address: _____
  _____
- ☐ Phone: _____
- ☐ Email: _____

NOTES:

SIGNATURE

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

Medical Director/Designate Name (please print): _____

Date: _____

Signature: _____

Please submit completed form to the College:

Accreditation Department
Sleep Medicine Diagnostics
College of Physicians & Surgeons of Alberta
2700, 10020 – 100 Street NW
Edmonton, Alberta T5J 0N3