DIAGNOSTIC ACCREDITATION PROGRAM
College of Physicians and Surgeons of British Columbia
300–669 Howe Street
Vancouver BC V6C 0B4
www.cpsbc.ca
Telephone: 604-733-7758
Toll Free: 1-800-461-3008 (in BC)
Fax: 604-733-3503

Assessor Application Form

DIAGNOSTIC IMAGING

APPLICANT INFORMATION

Name (as it appears on driver's licence or passport): ____________________

Credentials:
- ☐ MD
- ☐ RTR
- ☐ RTNM
- ☐ RDCS
- ☐ CRCS
- ☐ CRVS
- ☐ RTMR
- ☐ RDMS
- ☐ CRGS
- ☐ Other: ____________________

Areas of current practice:

Area	Number of years
☐ Radiology	Number of years: ________
☐ Complex Interventional Procedures (e.g. angiography)	Number of years: ________
☐ Ultrasound	Number of years: ________
☐ Mammography	Number of years: ________
☐ Echocardiography	Number of years: ________
☐ Computed tomography	Number of years: ________
☐ Magnetic resonance imaging	Number of years: ________
☐ Nuclear medicine	Number of years: ________
☐ Bone densitometry	Number of years: ________
☐ Other: ____________	Number of years: ________

PROFESSIONAL EXPERIENCE

If you require additional space, please attach a separate electronic document.

1. Please describe your current position and responsibilities.

____

____

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2. Please describe contributions you have made to your field of practice (board or committee memberships, academic appointments, papers, presentations or projects).

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Assessor Application Form *continued*

PROFESSIONAL EXPERIENCE

3. Please list any assessor experience with other accrediting bodies.

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4. Briefly indicate why you would like to be an assessor.

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____

5. Please attach a brief curriculum vitae.

FACILITY AFFILIATIONS

Facility name and position: ______________________________

Facility name and position: ______________________________

What months are best for you to participate in an assessment?

☐ January ☐ February ☐ March ☐ April ☐ May

☐ June ☐ September ☐ October ☐ November

How many months lead time do you need? ______________________________

Signature of immediate supervisor: ______________________________

Printed name: ______________________________ Date: ______________

BUSINESS ADDRESS

Facility name: ______________________________

Department: ______________________________

Street: ______________________________

City: ______________________ Province: ______________ Postal code: ______________

Daytime telephone: ______________________ Cell phone: ______________________

Email: ______________________________

Assessor Application Form *continued*

HOME ADDRESS

Street: ____________________

City: ____________ Province: ____________ Postal code: ____________

Daytime telephone: ____________ Cell phone: ____________

Email: ____________________

Emergency contact: ____________ Contact number: ____________

SHIPPING ADDRESS

Street: ____________________

City: ____________ Province: ____________ Postal code: ____________

To which address should mail and assessment packages be sent?

◯ Business address ◯ Home address ◯ Shipping address

Please return the completed form by email at diagnosticimaging@cpsbc.ca.

The information on this form is collected under the authority of section 5-21 of the Bylaws under the *Health Professions Act*, RSBC 1996, c.183. If you have any questions about the collection and use of this information, please contact the College at 300–669 Howe Street, Vancouver BC V6C 0B4 or by phone at 604-733-7758 or 1-800-461-3008 (toll-free in BC).