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

NEURODIAGNOSTICS

APPLICANT INFORMATION

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

Credentials: ☐ MD ☐ FRCPC ☐ RET ☐ REPT
☐ EPT ☐ RTEMG
☐ Other: _____

Areas of current practice:
☐ Electroencephalography (EEG) Number of years: _____
☐ Electromyography (EMG) and nerve conduction studies (NCS) Number of years: _____
☐ Evoked potentials (EP) 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.

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

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

Assessor Application Form *continued*

PROFESSIONAL EXPERIENCE

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

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: _____

HOME ADDRESS

Street: _____

City: _____ Province: _____ Postal code: _____

Daytime telephone: _____ Cell phone: _____

Email: _____

Emergency contact: _____ Contact number: _____

Assessor Application Form *continued*

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 neurodiagnostics@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).