RPAP
The Alberta Rural Physician Action Plan

PRIVILEGING ASSESSMENT APPLICATION

Please Print All Information Requested (Except Signature)

Name:

Last *First* *Middle* *Maiden*

Mailing Address:

Number *Street* *City* *Prov.* *Postal Code*

Telephone: Work (____) ____________________ Home (_____) ____________________

CELL (____) ____________________ Fax (_____) ____________________

Email address: ____

Date of Birth (dd/mm/yyyy) ______/_________/_________

Graduate of which Medical School? ____ **Year** ________

Certificant of the College of Family Physicians of Canada? ❑ No ❑ Yes Year ________

Fellow of the Royal College of Physicians and Surgeons of Canada? ❑ No ❑ Yes Year _________

CPSA Reg. No. _______________ **CMPA No.** _________________ **Code** _________ **Expiry Date**_______________

Current Location of Practice - Urban ❑ Rural ❑ Community: ____

Location in which you currently have a medical staff appointment and privileges:_______________________________________

*Attach privileging recommendation from PPAC

ASSESSMENT INFORMATION

Please attach CV and all relevant reference letters

Assessment Requested ____

____

Summarize relevant training in the discipline ____

____

____

Document experience and number of cases personally completed in the past 3 years _________________

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____

Availability: **From** (dd/mmm/yyy) ________/________/________ **To** (dd/mmm/yyy) ________/________/________

AHS / Preceptor

Has your AHS Medical Leader agreed to support for your assessment? (provide letter of support) ❑ No ❑ Yes

Will AHS cover any costs required to practice the new skills when the assessment is complete? ❑ No ❑ Yes

PLEASE NOTE: Documentation will be required before approval of your application.

Has a preceptor agreed/been identified to provide the assessment? ❑ No ❑ Yes

Preceptor's Name ____

Phone number (_____)____

Email address ____

If no preceptor has agreed to provide training, we will first forward your application when accepted to the Faculty liaison at the Universities of Calgary or Alberta.

Application Form Waiver

(Please Read Carefully)

In exchange for the consideration of my application, I agree that:

I will be required to participate in a program designed to evaluate the assessment process. This may include the maintaining of a log of procedures performed, cases seen and treated or referred, personal evaluation of your assessment and Alberta Health Services (AHS) response to your assessment. Both the AHS medical leader and I will be asked to comment on the program and areas for improvement. Therefore, I may be contacted in the future by the RPAP or its agents to assess the quality and effectiveness of the **Recruitment Support Program**, and I agree to be contacted and to participate in any evaluation for this purpose.

I also agree that the information collected from and during this application shall be used by RPAP for program administration, payment and evaluation of the Recruitment Support Program by the RPAP.

I authorize the investigation of all statements contained in this application. I understand that any misrepresentation or omission of facts called for is cause for rejection of my application or removal from training at any time without any previous notice. I hereby give the RPAP permission to contact medical schools, references, and others, and hereby release the RPAP, its employees and agents from any liability as a result of such contact.

I also understand that RPAP does not pay an honorarium, except to the assessing preceptor for their time and expertise.

I shall indemnify and hold harmless the RPAP, the Minister of Health and Wellness, their employees and agents from any and all claims, demands, actions and costs of any kind whatsoever, that may arise directly or indirectly out of any acts or omissions of myself during my period of training.

I commit to return to rural practice in Alberta after my assessment is completed.

Signature ____ Date: ______________________________

Please fax this form to 780-423-9917

OR

Email it to privileges@rpap.ab.ca

The personal information requested on this form Is collected for the purpose of administering and processing payments to preceptors, vendors, students, residents, contractors and staff involved with RPAP. If you have any questions about the collection, use, or disposal of the information requested, please contact: Executive Director, The Alberta Rural Physician Action Plan, 2801 Telus House, 10020–100 Street NW, Edmonton, AB T5J 0N3. Phone 780-423-9911 Fax: 780-423-9917.