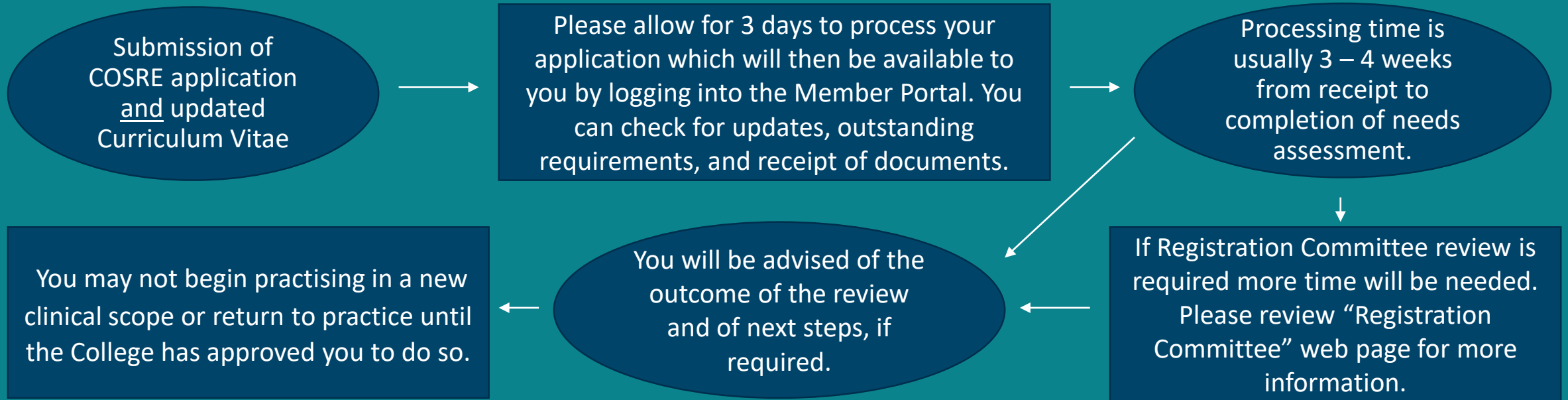


Change of Scope and Re-entering Practice (COSRE) Information Sheet



Having issues logging into Member Portal or uploading documents? Contact Inquiries at 416-967-2617 or inquiries@cpso.on.ca



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If you need to connect directly with COSRE staff please contact us at cosre@cpso.on.ca

Changing Scope of Practice Form

The purpose of this questionnaire is to provide the College with the **most current** information about you and your current practice, as well as your proposed “scope of practice.” You are requested to complete this application in accordance with the CPSO Policy “Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice” approved by CPSO Council in February 2018. The information you provide will be reviewed by the staff who support the Changing Scope of Practice process, and related Committees.

The CPSO may use this information for evaluation and research purposes to improve our quality improvement programs. All information made available to individuals or organizations external to College will be in aggregate, unidentifiable formats.

Surname (as indicated on CPSO register):

Given Name(s) (as indicated on CPSO register):

CPSO Number: Date of Birth (day/month/year): / /

Medical Degree from University of: Year:

Year internship/residency training completed:

Total years of post graduate training (internship/residency):

College of Family Physicians of Canada: Year: Enhanced Skills Program:

Royal College of Physicians and Surgeons of Canada:
 Year: Specialty: Subspecialty:

List of hospitals with which you are affiliated:

Admitting Privileges
 Yes No
 Yes No

Mailing Address

Hospital/Facility Name (if applicable) Street and Number Suite Number

City Province Postal Code Email Address

Office Telephone Preferred Phone Number

Current Primary Practice Address (location in which you see the majority of your patients)

Hospital/Facility Name (if applicable) Street and Number Suite Number

City Province Postal Code Email Address

Office Telephone Preferred Phone Number

What is your current scope of practice?

What is/are your proposed change in scope of practice?

Will you be changing your practice address if so, please give location and name of facility.

<i>Hospital/Facility Name (if applicable)</i>	<i>Street and Number</i>	<i>Suite Number</i>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<i>City</i>	<i>Province</i>	<i>Postal Code</i>	<i>Email Address</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Office Telephone</i>	<i>Preferred Phone Number</i>		
<input type="text"/>	<input type="text"/>		

What educational steps have you taken/do you propose to enable your change of scope?

What resources (clinical supervisors/colleagues/facility/ancillary) will be available to support your change?

I certify that the information provided on this application is correct and complete to the best of my knowledge.

Signature:

Date: