CPSO

Serving the people of Ontario through effective regulation of medical doctors

Change of Scope Application: Adult Chronic Pain Management

Dear Doctor:

The College is pleased to provide you with an application and information regarding changing the scope of your practice to include Adult Chronic Pain Management.

For your careful review, please read through the following links:

Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice Policy:
https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ensuring-Competence

Expectations for Physicians Who have Changed, or Plan to Change their Scope of Practice to Include Adult Chronic Pain Management: https://www.cpso.on.ca/CPSO/media/Documents/physician/polices-and-guidance/policies/change-scope-expectations-pain-medicine.pdf

Guidelines for College-Directed Clinical Supervision. For a changing scope of practice process clinical supervision is required:
http://www.cpso.on.ca/CPSO/media/documents/CPGs/Other/Guidelines-for-College-Directed-Clinical-Supervision.pdf

While the change in scope of practice process generally involves training, supervision and assessment, all of these components **may not** apply in every case. As with all requests for change in scope issues, in arriving at a decision, the CPSO will review each physician's applications and circumstances on an individual basis.

This application package contains the following:

- Requirements Checklist
- Application
- Interventional Pain Procedure List Template

In order to commence practice in an Out of Hospital Premise (OHP), you must complete this application form and all requirements set out in this schedule. For detailed information relating to the process and timelines, you may review the **Process and Timelines** document available under Reference Materials on the Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice policy page:
https://www.cpso.on.ca/CPSO/media/Documents/physician/polices-and-guidance/policies/changing-scope-of-practice-process-timelines.pdf

Please submit your application form along with all requested information to **cosre@cpso.on.ca**. Should you have any questions, please contact the Applications and Credentials Department at (416) 967-2617, Monday to Friday 8:00 am to 5:00 pm.

The College looks forward to receiving your application and wishes you success in your Changing Scope of Practice process.

Sincerely, Registration & Membership Services Department

REQUIREMENTS CHECKLIST

This checklist contains detailed information regarding the requirements and is provided as a reference to organizing your application. Please follow the instructions carefully in the schedule when completing each requirement.

PLEASE NOTE: The Changing Scope of Practice process and the Out of Hospital Premises Inspection Program are two distinct entities with separate requirements. You must follow instructions for the review, completion and submission of all requirements for each relevant program area.

☐ **1. Application Form**

Complete and return the attached application form for physicians proposing to change their scope of practice.

☐ **2. Updated Curriculum Vitae**

Curriculum vitae must list all qualifications; dates/locations of all training and practice appointments.

☐ **3. Name(s) and Updated Curriculum Vitae(s) of Proposed Clinical Supervisor(s)**

Clinical supervisors must be approved by the College before training can commence.

☐ **4. Name of ALL Out of Hospital Premise(s) you intend to train at**

Please note that you will **not** be permitted to practise in an OHP which is not identified in your application and subsequently approved by the College. Therefore, it is important to ensure that all locations of practice are provided and approved prior to your anticipated start date.

☐ **5. Interventional Pain Management Procedure List**

Each OHP has a distinct list of approved procedures that physicians may perform at the premises. You will be required to complete **separate** procedure lists for **each** OHP in which you intend to train.

Prior to submission, the procedure list must be reviewed and signed off by the Medical Director at each OHP in which you intend train to ensure that the premises is approved for all procedures identified.

☐ **6. Evidence of Education, Training and Experience**

Provide detailed information pertaining to your education, training and experience with respect to PM. Please include diplomas, certifications, Continuing Professional Development/Education transcripts, etc.

☐ **7. Additional Information**

Identify how many days per week you intend to train under supervision as well as your tentative start date for the period of supervised practice.

☐ **8. Sign and Return Clinical Supervision Agreement**

Following the assessment and approval of your application, you will receive via email, a Clinical Supervision Agreement which must be signed by yourself, your supervisor(s) and Medical Director(s), and submitted to cosre@cpso.on.ca. Upon receipt of your signed agreement, you will receive confirmation and approval from the OHPIP that you may commence practice in the approved premises.

☐ **9. Notify the Out of Hospital Premises Inspection Program**

Notify the OHPIP of your intention to practice in an OHP. You may do so online here:

https://members.cpso.on.ca/?v=members

College of Physicians and Surgeons of Ontario Application Form for Physicians Proposing To Change Their Scope of Practice to Include Adult Chronic Pain Management

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):____/____/____** **SEX (M/F):_____**

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: Certificant: Yes☐ No☐ Year _____ Member: Yes☐ No☐

Royal College of Physicians and Surgeons of Canada: Fellowship: Yes☐ No☐ Year _____ Specialty _____

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	*Home Telephone*		*Fax 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	*Home Telephone*		*Fax Number*

PART I: WHAT IS YOUR PROPOSED PRACTICE LOCATION?

***PROPOSED* PRACTICE ADDRESS** (*if different from current location -- location in which you will see the majority of your patients)*

Hospital/Facility Name (if applicable)		***Street and Number***	***Suite Number***
City	***Province***	***Postal Code***	***Email Address***
Office Telephone		***Home Telephone***	***Fax Number***

PART II: TELL US ABOUT YOUR CURRENT AND PROPOSED PRACTICE STRUCTURE

Please complete the following sections to the best of your ability. When answering the questions below, please note that:
***Current Practice** = your current clinical activities*
***Proposed Practice** = your current practice that you plan to continue and/or any new area of practice that you are proposing to add*

With reference to those questions about your proposed "scope of practice," please indicate "unknown" if you are unable to answer the question. Please do not leave blanks.

WITH WHOM DO YOU WORK IN YOUR CURRENT OFFICE PRACTICE AND WITH WHOM DO YOU PLAN TO WORK IN YOUR PROPOSED PRACTICE?

1. Please indicate the number of full-time and part-time personnel that you currently work with on a regular basis (daily/weekly) within your current office practice, as well as what you anticipate will be the situation in your proposed practice:

	CURRENT		PROPOSED		
FOR OFFICE PRACTICE	#FT	#PT	#FT	#PT	Unknown
Physicians					
Registered Nurses (RNs)					
Nurse Practitioners (NPs)					
Administrative Staff					
Other (please specify) _____					

2. Tell us what you share with other physicians in your current office practice as well as your proposed office practice.

FOR OFFICE PRACTICE	**CURRENT**		**PROPOSED**	
	YES	**NO**	**YES**	**NO**
Staff	☐	☐	☐	☐
Office space	☐	☐	☐	☐
Patient Records	☐	☐	☐	☐

TELL US ABOUT WHERE YOU CURRENTLY WORK AND WHERE YOU PLAN TO WORK

3. Please indicate in which location you see patients, the number of patients seen and the number of hours spent in direct patient contact during a **typical work-week**. Please also describe the number of patients, and the number of hours to be spent during direct patient contact in your ***proposed*** practice setting.

	CURRENT		**PROPOSED**	
Please complete the "current" and "proposed" columns for <u>only</u> those facilities that apply. **<u>Facility</u>**	# patients seen	# hrs spent in direct patient contact	Approx. # patients expected to be seen (If unknown, please mark "unknown")	Approx # hrs to be spent in direct patient contact (If unknown, please mark "unknown")
A. Office Practice: a) Private Office				
b) Health Service Organization (HSO)				
c) Community Health Centre				
d) Family Health Network				
e) Family Health Group				
f) Walk-in Clinic; After hours Clinic, Urgent Care Setting (e.g., generally no appointments; generally episodic care, non-static patient base)				
g) Academic Family Practice Teaching Unit				
h) Locum				
B. Hospital: a) Community Hospital				
> Inpatients				
> Outpatients				
> Emergency				
> Surgical Assist				
> Day Surgery				
> Hospitalist				
b) Academic/Teaching Hospital				
> Inpatients				
> Outpatients				
> Emergency				
> Surgical Assist				
> Day Surgery				
> Hospitalist				
C. Long-Term Care Facility/Nursing Home etc.				
D. Independent Health Facility (IHF)				
E. Out of Hospital Facilities (OHP)				
F. Government Facility (jail, military, etc.)				
G. House Call Service				
H. Other (please specify)_____				

COMMUNITY SERVICES

	CURRENT		PROPOSED		
	Yes	**No**	**Yes**	**No**	**Unknown**
4. a) Do you have access to basic laboratory services (e.g., hemoglobin, urine, blood glucose analyses, etc.)?	☐	☐	☐	☐	☐
b) Do you have access to advanced laboratory services (e.g., bone density, cardiac stress test, electromyography, etc.)?	☐	☐	☐	☐	☐
c) Do you have access to basic radiological services?	☐	☐	☐	☐	☐
d) Do you have access to CT or MRI?	☐	☐	☐	☐	☐
e) Do you have access to specialists for referral?	☐	☐	☐	☐	☐
f) Do you have regular contact and interaction with physicians in the same discipline in your community?	☐	☐	☐	☐	☐
g) Does your community have one or more long term care facilities?	☐	☐	☐	☐	☐
h) Does your community have a Community Care Access Centre (CCAC)?	☐	☐	☐	☐	☐
i) Do you have access to social service agencies to support medical care for your patients?	☐	☐	☐	☐	☐

TELL US ABOUT THE PROPOSED CHANGES TO YOUR "SCOPE OF PRACTICE"

5. a) Have you chosen to *focus or restrict* your practice? **YES** ☐ **NO** ☐

b) Have you chosen to *expand* your practice? **YES** ☐ **NO** ☐

c) Describe your proposed change in scope. How will it differ from your current practice?

CLINICAL ACTIVITY

6. Please describe your CURRENT and PROPOSED clinical practice **using the table of codes listed on page 6**. We would like you to reflect on your actual practice (i.e. "what you actually do"), rather than the certification(s) you may hold. If you list more than one code, please estimate the percentage of time you spend in each area.

CURRENT – What are you **currently** doing?

Code (3 digits)	0 – 10%	10 – 20%	20 – 40%	40 – 60%	60 – 80%	80% +
a)						
b)						
c)						
d)						
e) Other, please specify						

PROPOSED – What do you **propose** to do?

Code (3 digits)	0 – 10%	10 – 20%	20 – 40%	40 – 60%	60 – 80%	80% +
a)						
b)						
c)						
d)						
e) Other, please specify						

7. In a typical week, please estimate the percent of your **CURRENT** patient visits (left column) that fall within each of the following categories. Also, please estimate the percent of your patient visits that would likely fall within your **PROPOSED** practice (right column). *Please note that the total should equal 100 percent.*

CURRENT - Percent of patient visits	Category	PROPOSED – Percent of patients you anticipate in each area
	NEW PRESENTATIONS/ACUTE CONDITION MANAGEMENT – New or known patients with new complaints or condition requiring the formulation of a diagnosis in an office practice setting.	
	MANAGEMENT OF PATIENTS WITH ONGOING/CHRONIC CONDITIONS – Patients with chronic conditions requiring long-term monitoring with or without the presence of co-morbidities.	
	CONTINUITY OF CARE AND REFERRALS – Patients who you refer for treatment, surgical procedures, diagnostic procedures or otherwise, to the care of other physicians.	
	HEALTH MAINTENANCE – Patient visits for well care and preventive health maintenance (e.g. annual check-ups, screening, well baby visits, etc.).	
	PSYCHOSOCIAL CARE – Patients who you provide general counselling, psychotherapy sessions or referrals to various supportive social agencies in his/her community.	
	NEW CONSULTATIONS/PRE-OPERATIVE MANAGEMENT – New patients or known patients presenting prior to surgical/medical procedures for pre-operative examinations, testing and treatments.	
	OPERATIVE PATIENT MANAGEMENT AND PROCEDURES – Providing patients with intra-operative/procedural treatments.	
	POST-OPERATIVE MANAGEMENT AND FOLLOW-UP – Patient to whom you provide post-operative/post-procedural care, which may include follow-up of patients with conditions that may require long-term.	
	EMERGENCY MEDICINE MANAGEMENT - Patients to whom you provide care for in the emergency department.	
	OTHER (please specify) _____	
0	**TOTAL %**	0

Table of Practice Descriptors (*To be used for Question 6)*

	ANESTHESIA		**OBSTETRICS AND GYNECOLOGY**		**SURGERY**
101	Anesthesia	504	Gynecology	802	Assistance at Surgery
103	Chronic Pain Management with anesthesia	501	Gynecologic Oncology	803	Cardiovascular Surgery
102	Chronic Pain Management without general/spinal anesthesia	502	Gynecologic Reproductive Endocrinology & Fertility	804	Clinical Associates-Surgical
		503	Gynecologic Surgery without labour and delivery	805	Colorectal Surgery
	GENERAL/FAMILY PRACTICE	506	Obstetrics	806	Cosmetic Surgery
917	Episodic Care/Urgent Care/Walk-in	505	Obstetrical Practice without labour and delivery	931	Cosmetics-non surgical procedures
201	General/Family Practice with active/admitting hospital privileges			807	General Surgery
202	General/Family practice without hospital privileges		**PEDIATRICS**	808	General Surgical Oncology
927	Hospitalist	601	Neonatology	801	Laser Surgery
921	House Calls	602	Pediatrics	809	Neurosurgery
916	Long Term Care/Nursing Homes	607	Pediatric Allergy/Clinical Immunology	810	Ophthalmology
		603	Pediatric Cardiology	811	Orthopedic Surgery
	LABORATORY MEDICINE	933	Pediatric Endocrinology	812	Otolaryngology
401	Medical Biochemistry	610	Pediatric Gastroenterology	813	Plastic Surgery
402	Medical Microbiology	615	Pediatric Gynecology	819	Sclerotherapy
403	Pathology-Anatomic	611	Pediatric Hematology	814	Surgical Practice without operative treatment
407	Pathology-Forensic	612	Pediatric Hematology/Oncology	815	Thoracic Surgery
404	Pathology-General	613	Pediatric Infectious Diseases	818	Transplant Surgery
405	Pathology-Hematological	604	Pediatric Nephrology	816	Urology
406	Pathology-Neurological	605	Pediatric Neurology	817	Vascular Surgery
		608	Pediatric Oncology		
	MEDICINE	609	Pediatric Orthopedics		**OTHER**
301	Allergy	614	Pediatric Respiratory Medicine	901	Acupuncture
302	Cardiology	934	Pediatric Rheumatology	911	Addiction Medicine
303	Clinical Immunology	606	Pediatric Surgery	902	Administrative Medicine
304	Clinical Pharmacology			912	Aviation Medicine
305	Critical Care Medicine		**PSYCHIATRY**	908	Clinical Fellow-with moonlighting
306	Dermatology	910	Child and Adolescent Psychiatry	907	Clinical Fellow-without moonlighting
307	Emergency Medicine	321	Psychiatry	903	Community Medicine (Public Health)
308	Endocrinology	926	Psychoanalysis	915	Complementary Medicine
309	Gastroenterology	905	Psychotherapy	929	Consultations
310	Genetics			925	Coroner
311	Geriatric Medicine		**RADIOLOGY**	918	EEG
312	Hematology	704	CT (computed tomography)	919	EMG
324	Hepatology	701	Diagnostic Imaging	913	Hyperbaric/Diving Medicine
313	Infectious Diseases	705	Interventional Radiology	928	Locum
314	Internal Medicine	703	MRI	924	Managing practice (dealing with office staff, other business aspects of practice)
315	Medical Oncology	702	Therapeutic Radiology/Radiation Oncology	904	Palliative care
316	Nephrology			923	Research
317	Neurology			914	Sleep Medicine
318	Nuclear Medicine			920	Spirometry
319	Occupational Medicine			906	Sport Medicine
320	Physical Medicine and Rehabilitation			922	Teaching
322	Respiratory Medicine			930	Travel & Tropical Medicine
323	Rheumatology				

8. Please list at least 5-10 of the most common **conditions/diseases** that you CURRENTLY see in your practice as well as those you expect to see in your PROPOSED practice:

CURRENT PRACTICE (Most Common Conditions/Diseases)	PROPOSED PRACTICE (Most Common Conditions/Diseases)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.

Please list 5 of the most common **procedures** that you CURRENTLY perform in your practice as well as those you expect to perform in your PROPOSED practice:

FORMER PRACTICE (Most Common Procedures)	PROPOSED PRACTICE (Most Common Procedures)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

9. a) Within the past 2 years, have you undergone formal training in your **proposed** practice area? **YES** ☐ **NO** ☐

b) Within the past 2 years, what proportion of your current practice includes the same types of patients (i.e. same conditions, treatments and/or procedures) that you will care for in your **proposed** new area of practice? _____ %

c) In your **proposed** scope of practice, will you be practising within a hospital or group practice setting? **YES** ☐ **NO** ☐

d) In your **proposed** scope of practice, will you be caring for a similar or a fewer number of patients per week on average as you do in your current type of practice? **YES** ☐ **NO** ☐

PART III: TELL US ABOUT YOUR CONTINUING PROFESSIONAL DEVELOPMENT AND CONTINUING MEDICAL EDUCATION

1. If you have completed or plan to complete any formal training or educational enhancement (e.g. courses, seminars, etc.) in preparation for your proposed "scope of practice", **please describe your completed or proposed training in detail, including: content, duration and location of the training. Limited space is provided below; however, please feel free to attach any applicable information to this application**.

Question 2 provides information about the type of professional development activities in which you participated in the past 12 months and the amount of time spent within each activity.

2. a) Regardless of your certification or membership status with the RCPSC or the CFPC do you voluntarily fulfil their professional development requirements?

YES ☐ **NO** ☐ **UNSURE** ☐

b) Please estimate how many hours you spent in the following formal CPD activities in the past 12 months:

	0 - 10hrs	**10 - 20hrs**	**20 - 30hrs**	**30 - 40hrs**	**40+ Hrs**
RCPSC/CCFP accredited courses, conferences and workshops	☐	☐	☐	☐	☐
Internet based CPD activities (e.g. on-line journals, guidelines, etc)	☐	☐	☐	☐	☐
Practice-based small group learning sessions (PBSGL)	☐	☐	☐	☐	☐
Self-directed learning programs	☐	☐	☐	☐	☐
Hospital Committees	☐	☐	☐	☐	☐
Hospital educational rounds/sessions	☐	☐	☐	☐	☐
Reading journals	☐	☐	☐	☐	☐
Other courses, conferences and workshops	☐	☐	☐	☐	☐
Other *(Please describe below)*	☐	☐	☐	☐	☐

PART IV: SUPERVISION PROCESS

As part of your changing scope of practice process, you may need to undergo a period of graded supervision, followed by a College-directed assessment of your abilities. You need to recruit one or more clinical supervisors to assist you in your changing scope of practice process. It is advisable to have more than one clinical supervisor.

Your proposed clinical supervisor(s) must be acceptable to the College. For characteristics of an acceptable supervisor, please see the College document entitled *Guidelines for College-Directed Clinical Supervision:*
https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/your-practice/quality-in-practice/cpgs-other-guidelines/clinical-supervision-guidelines.pdf

Your graded supervision may take place in three levels: High, Moderate, and Low Level Supervision.

<u>High Level Supervision</u>

- Supervisor is the Most Responsible Physician (MRP)
- Supervisor to provide direct observation of all clinical activities initially, and then at his/her discretion
- Supervisor must be on site and approve patient care decisions and management plans
- Must be available in person at all times to review treatment plans

<u>Moderate Level Supervision</u>

- Physician is the MRP
- Supervisor is immediately available by phone or email
- If the clinical scope of practice involves procedures, supervisor must be on-site and immediately available
- Supervisor reviews a selection of cases initially weekly, progressing to biweekly review at the College's/Supervisor's discretion, and provides feedback to the physician on documentation and care

<u>Low Level Supervision</u>

- Physician is the MRP
- Supervisor must be available by phone or email to discuss cases
- Supervisor to review a selection of cases on a monthly basis

PROPOSED SUPERVISOR(S):

NAME & CPSO#: _____

NAME & CPSO#: _____

Tentative Start Date: _____

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

SIGNATURE: _____ **DATE:** _____

PAIN MEDICINE PROCEDURE LIST

Below is a listing of procedures appropriately performed in interventional clinics. Some of these benefit from imaging guidance. Treatment may include injection of medications and/or use of radio frequency lesioning or pulsed treatment.

CRANIAL NERVE BLOCKS/DEEP NERVES OF THE HEAD AND NECK	***To be trained:***	***Performed in the last 2 years:***	***Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:***
Trigeminal/Ganglion Block	☐	☐	
Sphenopalatine Ganglion Block	☐	☐	
Glossopharyngeal Nerve Block	☐	☐	
Hypoglossal Nerve Block	☐	☐	
Maxillary Nerve Block	☐	☐	
Spinal Accessory Nerve Block	☐	☐	
Superficial branches of CN V	☐	☐	
Mandibular Nerve Block	☐	☐	
Auriculotemporal Nerve Block	☐	☐	
Infraorbital Nerve Block	☐	☐	
Mental Nerve Block	☐	☐	
Supraorbital Block	☐	☐	
Zygomatic Temporal Nerve Block	☐	☐	
Occipital	☐	☐	

NEURAXIAL BLOCKS	***To be trained:***	***Performed in the last 2 years:***	***Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:***
Central neuraxial blocks including: Intrathecal blocks	☐	☐	
Spinal cord stimulation	☐	☐	
Epidural blocks (please specify) • Interlaminar • Transforaminal • Caudal	☐	☐	
Epidural Adhesiolysis	☐	☐	
Nerve root blocks	☐	☐	
Blocks involving the facet joints: Medial branch block	☐	☐	
Peri-articular facet blocks	☐	☐	
Paravertebral nerve blocks	☐	☐	
Provocative discography	☐	☐	
Kyphoplasty	☐	☐	
Biacuplasty	☐	☐	

PERIPHERAL NERVE BLOCKS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Femoral	☐	☐	
Sciatic	☐	☐	
Popliteal	☐	☐	
Intercostal	☐	☐	
Pudendal	☐	☐	
Proximal Radial/Median/Ulnar	☐	☐	
Suprascapular/transcapular	☐	☐	
Ilioinguinal/iliohypogastric	☐	☐	
Genitofemoral	☐	☐	

PLEXUS BLOCKS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Deep Cervical	☐	☐	
Upper extremity/Brachial	☐	☐	
Coeliac	☐	☐	
Lower Extremity/Lumbar	☐	☐	
Hypogastric plexus	☐	☐	
Ganglion of impar	☐	☐	
Superficial Cervical	☐	☐	

SYMPATHETIC NERVE BLOCKS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Stellate ganglion	☐	☐	
Lumbar sympathetic	☐	☐	

INTRAVENOUS BLOCKS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Local Anaesthetic	☐	☐	

INTRAVENOUS INFUSIONS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Lidocaine	☐	☐	
Ketamine	☐	☐	

JOINTS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Sacroiliac joints	☐	☐	

NEUROABLATIVE BLOCKS	*To be trained:*	*Performed in the last 2 years:*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*
Radiofrequency Ablation	☐	☐	

OTHER: *Please list additional pain medicine procedures in which you intend on performing which are not included in the list above (i.e neurotomies, nerve hydrodissection)*	*Please identify if you are using Ultrasound or Fluoroscopy Guidance, if applicable:*

MEDICAL DIRECTOR DECLARATION

I, Dr. _____ (CPSO# _____), have reviewed the Pain Medicine Procedure List completed by Dr. _____ (CPSO# _____). I confirm that all of the procedures identified in the list are approved to be performed at the following Out of Hospital Premises:

_____

_____ _____

Medical Director Signature Date