CPSO

Trusted Doctors
Providing Great Care

Change of Scope Application: Cosmetic Procedures

Dear Doctor:

The College is pleased to provide you with an application and information regarding changing the scope of your practice to include Cosmetic Procedures.

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

Framework – Expectations for Physicians Who have Changed or Plan to Change their Scope of Practice to Include Surgical Cosmetic Procedures:
https://www.cpso.on.ca/CPSO/media/Documents/physician/polices-and-guidance/policies/change-scope-expectations-cosmetic-surgery.pdf

Guidelines for College-Directed Supervision. For a changing scope of practice process, it is Clinical Supervision:
https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/CPGs-Other-Guidelines/Guidelines-for-College-Directed-Supervision

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.

Please complete and submit the application form and all the 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 Related Topics on the Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice policy page.

This application package contains the following:

- Requirements Checklist
- Application

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 a 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. Notification must be made to the OHPIP if you intend to perform any cosmetic procedures that fall under the OHPIP Standards.

https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Clinic-Inspections-Special-Programs/Out-of-Hospital-Premises-Inspection-Program

☐ **1. Application Form**

Complete and return the attached application form for physicians proposing to change their scope of practice. Email (cosre@cpso.on.ca), mail, or courier your application to the College. Faxed applications are not acceptable.

Applications not finalized after one year will be considered withdrawn.

☐ **2. Updated Curriculum Vitae**

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

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

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

☐ **4. Name(s) and Updated Curriculum Vitae(s) of Proposed Clinical Supervisor(s) – if required**

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

☐ **5. Additional Information – if required**

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.

☐ **6. Sign and Return Clinical Supervision Agreement – if required**

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.

If notification to OHPIP is required:

☐ **7. 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.

☐ **8. Notify the Out of Hospital Premises Inspection Program (if required)**

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 Cosmetic Procedures

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: Fellow 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*

Former Primary Practice Address *(location in which you saw 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 perform cosmetic procedures)*

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

City	*Province*	*Postal Code*	*Email Address*

Office Telephone	*Home Telephone*	*Fax Number*

Type of Accreditation

- ☐ Hospital
- ☐ Canadian Association of Accreditation Ambulatory Surgical Facilities
- ☐ Other (please specify): _____

Type of Anesthetic Provided to Cosmetic Patients

- ☐ Local Anesthetic
- ☐ General Anesthetic
- ☐ Procedural Sedation

If you selected Procedural Sedation, please indicate (check all that apply)

- ☐ PO
- ☐ IM
- ☐ IV
- ☐ Inhalational (e.g. nitrous oxide)

PROPOSED PRACTICE ADDRESS 2 (*if applicable)*

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

City	*Province*	*Postal Code*	*Email Address*

Office Telephone	*Home Telephone*	*Fax Number*

Type of Accreditation

- ☐ Hospital
- ☐ Canadian Association of Accreditation Ambulatory Surgical Facilities
- ☐ Other (please specify): _____

Type of Anesthetic Provided to Cosmetic Patients

- ☐ Local Anesthetic
- ☐ General Anesthetic
- ☐ Procedural Sedation

If you selected Procedural Sedation, please indicate (check all that apply)

- ☐ PO
- ☐ IM
- ☐ IV
- ☐ Inhalational (e.g. nitrous oxide)

PROPOSED PRACTICE ADDRESS 3 (*if applicable)*

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

City	*Province*	*Postal Code*	*Email Address*

Office Telephone	*Home Telephone*	*Fax Number*

Type of Accreditation

- ☐ Hospital
- ☐ Canadian Association of Accreditation Ambulatory Surgical Facilities
- ☐ Other (please specify): _____

Type of Anesthetic Provided to Cosmetic Patients

- ☐ Local Anesthetic
- ☐ General Anesthetic
- ☐ Procedural Sedation

If you selected Procedural Sedation, please indicate (check all that apply)

- ☐ PO
- ☐ IM
- ☐ IV
- ☐ Inhalational (e.g. nitrous oxide)

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 <u>and/or</u> any new area of practice that you are proposing to add*

With reference to those questions about your <u>proposed</u> "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 <u>current</u> office practice, as well as what you anticipate will be the situation in your <u>proposed</u> practice:

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

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

2. 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	Approx # hrs to be spent in direct patient contact
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**
3. 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"

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

b) have you chosen to expand your practi0e? **YES** ☐ **NO** ☐

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

CLINICAL ACTIVITY

What percentage of your time will you spend doing:

	0-10%	11-20%	21-40%	41-60%	61-80%	81%+
a) Cosmetic surgical procedures	☐	☐	☐	☐	☐	☐
b) Cosmetic non-surgical procedures	☐	☐	☐	☐	☐	☐
c) Other clinical work	☐	☐	☐	☐	☐	☐

5. 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

Cosmetic Procedures

6. Please complete the table below and indicate the frequency and location of each cosmetic procedure listed below.

	NAME OF PROCEDURE	**FREQUENCY (Procedures/month)**	**Procedure performed at:** (Please checkmark each location that cosmetic procedure is performed.)		
			Practice Address 1	Practice Address 2	Practice Address 3
HIGH RISK PROCEDURES (Surgical and non-surgical)					
	Abdominoplasty/Tummy Tuck		☐	☐	☐
	Belly Button Surgery/Umbillicoplasty		☐	☐	☐
	Blepharoplasty/Eyelid Surgery		☐	☐	☐
	Brachioplasty		☐	☐	☐
	Breast implant/Augmentation		☐	☐	☐
	Breast Lift/Mastopexy		☐	☐	☐
	Breast Reduction (Female)		☐	☐	☐
	Breast Reduction (Male)		☐	☐	☐
	Browlift/Endoscopic Browlift/Forehead Lift		☐	☐	☐
	Buttock Implant		☐	☐	☐
	Buttock Lift		☐	☐	☐
	Calf Implant		☐	☐	☐
	Cheek Implant/Cheek Bone Surgery		☐	☐	☐
	Chin Surgery/Genioplasty		☐	☐	☐
	Correction Breast Symmetry		☐	☐	☐
	Correction Inverted Nipples		☐	☐	☐
	Deep Chemical Peel		☐	☐	☐
	Dermabrasion		☐	☐	☐
	Ear Surgery/Setback Otoplasty		☐	☐	☐
	Endovenous Laser Treatment (EVLT)		☐	☐	☐
	Fat Implant/Fat Injection		☐	☐	☐
	Hair Transplant (FUE, FUT)		☐	☐	☐
	Labiaplasty/Labia Reduction		☐	☐	☐
	Laser Skin Resurfacing of the Dermis		☐	☐	☐
	Lip Implant		☐	☐	☐
	Lipoplasty		☐	☐	☐
	Liposuction (any volume)		☐	☐	☐
	Lower Body Lift		☐	☐	☐
	Malarplasty		☐	☐	☐
	Pectoral Implant		☐	☐	☐
	Penis Augmentation/Enlargement/Phalloplasty		☐	☐	☐
	Rhinoplasty/Nose Job		☐	☐	☐
	Rhytidectomy/Face Lift/Neck Lift		☐	☐	☐
	Scalp Surgery		☐	☐	☐
	Suture Face Lift/Thread Lift		☐	☐	☐
	Thigh Lift/Thighplasty		☐	☐	☐
	Permanent Fillers		☐	☐	☐
	Ablative Lasers		☐	☐	☐

II. If practising in a private office, what does your practice structure look like?

1. Do your practice locations have discharge protocols?
   - ☐ Yes
   - ☐ No

2. Who discharges patients from your practice locations?

3. Please briefly describe your arrangements to ensure care for your cosmetic patients following discharge:

4. Do you have 911 access?
   - ☐ Yes
   - ☐ No

5. Please outline in detail the training and length of time in each program you have received with respect to your cosmetic practice.

Name and Details of Training Program	**Length of Time**

6. Please list any medical/healthcare societies or groups to which you belong that are relevant to your cosmetic practice and indicate how your membership supports your practice.

Name of Medical /Healthcare Society	Relevance

III. Continuing Professional Development/Continuing Medical Education Specific to your Cosmetic Practice

Please provide information about the type of professional development activities specific to your cosmetic practice in which you participated in the past 12 months and the amount of time spent within each activity.

Please estimate how many hours you spent in the following formal CME activities in the past 12 months.

	0 - 10hrs	**11 - 20hrs**	**21 - 30hrs**	**31 - 40hrs**	**41+ hrs**
RCPSC/CCFP accredited courses, conferences and workshops	☐	☐	☐	☐	☐
Internet based CME Activities (e.g. on-line journals, Guidelines etc)	☐	☐	☐	☐	☐
Practice-based small group learning sessions	☐	☐	☐	☐	☐
Self-directed learning programs	☐	☐	☐	☐	☐
Hospital Committees	☐	☐	☐	☐	☐
Hospital educational rounds	☐	☐	☐	☐	☐
Reading Journals	☐	☐	☐	☐	☐
Other courses, conferences and workshops	☐	☐	☐	☐	☐
Other *(Please describe below)*	☐	☐	☐	☐	☐

PART IV: SUPERVISION PROCESS

As part of your changing scope of practice process, if you wish to perform high risk and/or surgical cosmetic procedures, 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/CPSO/media/documents/CPGs/Other/Guidelines-for-College-Directed-Clinical-Supervision.pdf*

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

High Level Supervision

- 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

Moderate Level Supervision

- 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

Low Level Supervision

- 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:** _____