

### Checklist for Completion of Training Requirements in Sleep Medicine Pathway 3

This checklist follows the mandatory components of training in sleep medicine for physicians who have followed Pathway 3. Please complete all components of the following checklist for consideration of acceptance of your training in sleep medicine.

Name of Physician Changing Scope of Practice: \_\_\_\_\_

CPSO Number: \_\_\_\_\_

- a. Completed a personalized training program in sleep medicine with a duration equivalent to 12 months of full time training. The program must be structured such that it:**

- Please document dates and duration of training in the table below. Use additional pages as necessary:

	Location	Start Date	Stop Date	Total Days	Supervisor's Initials
<b>Document Location and dates of training with supervisor's initials</b>					

**i. Contains all components contained within the attached document entitled “Mandatory Components of Sleep Medicine Training Programs in Ontario”.**

- Please have supervisors initial each mandatory component of training below to attest to completion of training.

**1. Technical and Other Skills**

Trainees must have formal instruction, clinical experience, and demonstrated competence at the completion of education in the following:

- A) the indications for and potential pitfalls and limitations of diagnostic tests and the interpretation of the results in the context of the clinical situation. These diagnostic tests must include the following:
  - a. polysomnography, scoring and interpretation of polysomnograms and recognition of artifacts, including:
    - i) performance and interpretation of CPAP titrations;
    - (ii) performance and interpretation of bilevel titrations;
    - (iii) performance and interpretation of adaptive servoventilation studies.
  - b. multiple sleep latency testing;
  - c. maintenance of wakefulness testing;
    - a. evaluation of polysomnograms that involve treatment, including dental devices, positive airway pressure therapy, etc.;
  - e. compliance reports for use of positive airway pressure therapy or other devices.
- B) skills necessary to perform polysomnographies from preparation and hookup of the patient to the completion of the study, including multiple sleep latency and maintenance of wakefulness tests.
- C) scoring and interpretation of polysomnograms and recognition of artifacts.
- D) Consultative skills in sleep medicine in a variety of medical, surgical, and psychiatric settings.

*I certify that each of the above components of training have been completed satisfactorily:*

*Name of Supervisor:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Initials of Supervisor:* \_\_\_\_\_

## 2. Foundational Knowledge of Sleep

Trainees must have formal instruction in, and demonstrate comprehensive knowledge of:

- A) fundamental mechanisms of sleep, major theories in sleep medicine, and the generally-accepted facts of basic sleep mechanisms:
  - a. Basic neurological sleep mechanisms;
  - b. Chronobiological mechanisms;
  - c. Respiratory physiology during sleep and pathophysiology;
  - d. Cardiovascular physiology during sleep and pathophysiology;
  - e. Sleep across the life span.
- B) airway anatomy.
- C) nosology for sleep disorders: The International Classification of Sleep Disorders.
- D) etiopathogenic characterization of sleep disorders.
- E) pharmacology of sleep (i.e. medication effects on sleep).

*I certify that each of the above components of training have been completed satisfactorily:*

*Name of Supervisor:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Initials of Supervisor:* \_\_\_\_\_

### 3. Clinical Assessment Skills

Trainees must have formal instruction in, and demonstrate comprehensive knowledge of clinical manifestations of the following aspects of sleep disorders.

- A) evaluation of patients presenting with excessive sleepiness;
- B) evaluation of patients presenting with difficulty initiating or maintaining sleep;
- C) evaluation of patients presenting with parasomnias;
- D) biological rhythm disorders;
- E) medical, neurologic, and psychiatric disorders displaying symptoms likely to be related to sleep disorders (e.g., the relationship between hypertension and snoring);
- F) biological, psychological, social, economic, ethnic, and familial factors which significantly influence the evaluation and treatment of sleep disorders; and
- G) the nature of the interactions between treatment for sleep disorders and other medical, neurologic, and psychiatric treatment.

*I certify that each of the above components of training have been completed satisfactorily:*

*Name of Supervisor:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*Initials of Supervisor:* \_\_\_\_\_

#### 4. Diagnostic Skills

Trainees must have formal instruction in, and demonstrate comprehensive knowledge of diagnostic strategies in sleep disorders.

- A) etiologies, prevalence, diagnosis, and treatment of all of the sleep disorders in the current nosology of sleep medicine;
- B) the use, reliability, and validity of the generally-accepted techniques for diagnostic assessment

*I certify that each of the above components of training have been completed satisfactorily:*

*Name of Supervisor:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Initials of Supervisor:* \_\_\_\_\_

#### 5. Treatment of Sleep Disorders

Trainees must have formal instruction in, and demonstrate comprehensive knowledge in the treatment of sleep disorders

- A) treatment approaches for obstructive sleep apnea, to include nasal CPAP, bilevel PAP, upper airway surgery, oral appliances, and position education;
- B) treatment of Central Sleep Apnea
- C) treatment approaches for insomnia, to include cognitive-behavioral therapies and pharmacological therapy;
- D) treatment approaches for narcolepsy and idiopathic CNS hypersomnolence;
- E) treatment approaches for parasomnias;

- F) treatment of circadian rhythm disorders;
- G) treatment of obesity hypoventilation syndrome.

*I certify that each of the above components of training have been completed satisfactorily:*

*Name of Supervisor:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Initials of Supervisor:* \_\_\_\_\_

#### 6. Other Aspects of Sleep Medicine

Trainees must have formal instruction in, and demonstrate comprehensive knowledge in the following other aspects of Sleep medicine

- A) legal aspects of sleep medicine;
- B) critically appraising the professional and scientific literature, and applying new contributions to management and care of patients.

*I certify that each of the above components of training have been completed satisfactorily:*

*Name of Supervisor:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Initials of Supervisor:* \_\_\_\_\_



ii. **Has a minimum of two supervisors, acceptable to the College, who agree to report on the content of the training no less than quarterly. The supervisors agree to be the most responsible physician (MRP) for all patient assessments for the duration of the training program.**

**Attestation of Supervisors** (use additional pages as necessary)

**Supervisor 1**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

CPSO Number: \_\_\_\_\_

*I hereby certify that I have acted as a supervisor for Dr. \_\_\_\_\_ for the purposes of training in sleep medicine. During my period of high supervision with Dr. \_\_\_\_\_ I have acted as the most responsible physician for all patient care.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Supervisor 2**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

CPSO Number: \_\_\_\_\_

*I hereby certify that I have acted as a supervisor for Dr. \_\_\_\_\_ for the purposes of training in sleep medicine. During my period of high supervision with Dr. \_\_\_\_\_ I have acted as the Most Responsible Physician for all patient care.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**List of Reports** – Please use the table below to outline reports sent to the College by supervisors

Name of Supervisor	Date of Report	Training period covered

**iii. A formal, regular evaluation process**

- Please detail the evaluation process utilized in the training program in the space below.



**iv. Written objectives of training.**

- Please attach written objectives of training.

**v. A mechanism to report the supervisors' assessment of the individual's competence at the end of the program.**

- Please attach a final assessment of the physician's competence from each supervisor at the end of the training program.

**vi. A mechanism to document all training experiences including the number and types of all sleep studies interpreted equivalent to that which is contained in the CPSO IHF Sleep Medicine Checklist.**

- Please complete this checklist and have it initialed by your supervisor(s)

	<b>Trainee</b>	<b>Supervisor</b>
I have received an equivalent of at least 12 months full-time hours experience and training in sleep medicine		
My Supervisor is a qualified Sleep Specialist		
I have personally set-up at least 5 patients for overnight studies		
I have personally scored at least 25 sleep studies (should be a sufficient broad spectrum of studies to ensure proper training, e.g. sleep apnea, insomnia, etc.)		
I have reviewed and interpreted the raw data of at least 200 polysomnograms		
I have personally interpreted 50 CPAP titration studies		
I have personally supervised and interpreted 5-10 BiPAP titration studies		
I have personally interpreted at least 20-25 MSLTs		
I have personally interpreted at least 10 MWTs		
I have evaluated at least 25 insomnia patients		
I have evaluated at least 10 patients with RLS/PLMS		
I have evaluated at least 50 obstructive apnea patients		
I have evaluated at least 10 central apnea patients		
I have evaluated and managed at least 10 narcolepsy/idiopathic hypersomnolence patients		
I have evaluated and managed at least 10 patients with circadian		



rhythm sleep disorders		
I have evaluated and managed at least 10 parasomnia patients		
I have triaged at least 200 patients		
I have been trained to report to the Ministry of Transportation regarding driver’s license revocations		

**vii. The program must be completed in less than 36 months**

- Please enter start and finish dates of program below:

Start Date: \_\_\_\_\_ Finish Date: \_\_\_\_\_

**viii. The proposed program, including supervisors, must be evaluated by the CPSO to ensure that they are acceptable before the physician embarks on the training.**

- CPSO Staff to confirm acceptance of program prior to starting program

**Attestation**

I hereby declare that I have received the training and have the experience required to practice in the field of sleep medicine and that all information provided above is correct.

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_