

**This is a fillable form. Please print and sign when completed.**

**Complete the following application forms:**

**Form A:** Application form

**Form B:** Payment information

**Form C:** Declaration of understanding and release of information  
• **This form must be printed, signed, and dated by you and a witness**

**Form D:** Scope of practice  
• Describes your current scope of practice. This is reviewed by members of your discipline's specialty committee ensuring that your current practice profile has the necessary breadth to be assessed for the specialty.

**Attach an up-to-date CV summarizing the following:**

- Medical school name, graduating year, country
- Postgraduate training appointments: *start and end dates (month/year), number of months, hospital/university, specialty, level of training*
- Specialty certification(s) received: *date, name of certification, jurisdiction (country/province/state etc.)*
- Practice details: *start and end dates (month/year), type of practice, location (city/province/state/country etc.)*
- All your previous and current medical licenses from every jurisdiction since your graduation from medical school: *date, type, jurisdiction (country, province, state etc.)*
- Explain any gaps longer than three (3) or more consecutive months in your history of training and practice.

**Important Notes**

- Return all forms completed in full to the Royal College using the contact information below
- You will receive e-mail confirmation that your application has been received
- The Royal College will remain in contact with you via e-mail. Contact [coa@royalcollege.ca](mailto:coa@royalcollege.ca) or update your contact information online at [www.royalcollege.ca/coa](http://www.royalcollege.ca/coa)  
*Please ensure that we have your current e-mail address on file*
- Applications will be reviewed in the sequence in which they are received
- You will be contacted directly if we require any additional information

**Contact Information**

**Web:** [royalcollege.ca/per](http://royalcollege.ca/per)

**Phone:** 1-800-267-2320

**Fax:** 613-730-3707

**E-mail:** [per@royalcollege.ca](mailto:per@royalcollege.ca)

**Mail:** Royal College of Physicians and Surgeons of Canada

Credentials Unit

774 Echo Drive

Ottawa, ON K1S 5N8

**Verification of your postgraduate medical education (PGME) and practice documentation:**

Copies of any Canadian licensure and training documentation should be included with your application.

All international licensure and training documentation must be source verified by physiciansapply.ca.

- Open an account with physiciansapply.ca (physiciansapply.ca will establish a confidential, lifetime portfolio for you).
- Upload the required documentation.
- Activate sharing to allow the Royal College to view your source verified documents.

**Evidence of practice as an independent specialist in the specialty applied for:**

|   |  |
|---|--|
| <input type="checkbox"/> Non-Canadian licensure:<br>Submit to <b>physiciansapply.ca</b> for verification<br><br><input type="checkbox"/> Canadian licensure:<br>Submit to <b>per@royalcollege.ca</b> for verification | <p><b>Proof of practice for your last five years of practice</b></p> <ul style="list-style-type: none"> <li>• Provide a copy of specialist licensure for all of the jurisdictions that you currently hold or have held licensure to practice</li> <li>• Include your current medical license to practice in Canada</li> </ul>  |
| <input type="checkbox"/> Submit to <b>physiciansapply.ca</b> for verification   | <p><b>Proof of eligibility to practice as an independent specialist in the jurisdiction of training</b></p> <ul style="list-style-type: none"> <li>• Copy of licensure from the jurisdiction of training showing that you practiced as an independent specialist in the specialty applied for<br/><i>and/or</i></li> <li>• Specialty certificates/diplomas received from jurisdiction of training</li> </ul> |
| <input type="checkbox"/> Submit to <b>per@royalcollege.ca</b> for verification  | <p><b>Certificate of Professional Standing</b></p> <ul style="list-style-type: none"> <li>• Order a Certificate of Professional Standing from your Medical Regulatory Authority (MRA). The certificate must be ordered by you and sent to the Royal College directly</li> <li>• In general there is an online link on your MRA website to release the certificate to the Royal College</li> </ul>            |

**Evidence of specialty training**

**Note:** If the Royal College has already completed an assessment of your specialty training due to an application through an alternate route, additional verification of your training by physiciansapply.ca is *not* required.

|   |  |
|---|--|
| <input type="checkbox"/> Submit to <b>physiciansapply.ca</b> for verification | <p><b>Copy of your Medical Degree</b></p> <ul style="list-style-type: none"> <li>• Example: MD, MBBS</li> </ul>  |
| <input type="checkbox"/> Submit to <b>physiciansapply.ca</b> for verification | <p><b>Documented evidence of postgraduate training completed to date</b></p> <p>Example:</p> <ul style="list-style-type: none"> <li>• Completion of training certificate<br/><b>or</b></li> <li>• Written confirmation from the program director of your training program indicating the scope of your training and the start and finish dates</li> </ul> <p><b>Note:</b> If you trained in a number of locations and institutions submit documentation for all periods of training.</p> |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form A: Application form ANESTHESIOLOGY**

**Examination/Assessment Details**

Please indicate which examination year you are interested in →

**Route A:** the existing Royal College certification exams

Exam/assessment year applying for

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Your letter of eligibility will be prepared based on the above information.

**Personal Details**

**Identification**

|                                  |                               |                              |                           |                      |                            |                              |
|----------------------------------|-------------------------------|------------------------------|---------------------------|----------------------|----------------------------|------------------------------|
| Title                            | <input type="radio"/> Dr.     | <input type="radio"/> Dr     | <input type="radio"/> Dre | Sex                  | <input type="radio"/> Male | <input type="radio"/> Female |
| Language                         | <input type="radio"/> English | <input type="radio"/> French | Date of birth             | <input type="text"/> | <input type="text"/>       | <input type="text"/>         |
|                                  |                               |                              |                           | <i>DD</i>            | <i>MMM</i>                 | <i>YYYY</i>                  |
| Royal College ID (if applicable) | <input type="text"/>          |                              |                           |                      |                            |                              |
| Surname                          | <input type="text"/>          |                              |                           |                      |                            |                              |
| Middle name(s)                   | <input type="text"/>          |                              |                           |                      |                            |                              |
| Given name                       | <input type="text"/>          |                              |                           |                      |                            |                              |

**Contact Information**

Home address  Business address

|                            |                                |                            |                                |
|----------------------------|--------------------------------|----------------------------|--------------------------------|
| Street name and number     | <input type="text"/>           | Apt number                 | <input type="text"/>           |
| City                       | <input type="text"/>           | Province                   | <input type="text"/>           |
|                            |                                | Postal code                | <input type="text"/>           |
| Phone number               | <input type="text"/>           | Phone number               | <input type="text"/>           |
| <input type="radio"/> Home | <input type="radio"/> Business | <input type="radio"/> Cell | <input type="radio"/> Home     |
|                            |                                |                            | <input type="radio"/> Business |
|                            |                                |                            | <input type="radio"/> Cell     |
| E-mail                     | <input type="text"/>           | E-mail                     | <input type="text"/>           |
| <input type="radio"/> Home | <input type="radio"/> Business | <input type="radio"/> Home | <input type="radio"/> Business |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form A:** Application form  
**ANESTHESIOLOGY**

**Contact details for your current Chief of Staff/supervisor**

Your chief of staff/supervisor will be asked to verify your submitted scope of practice and practice competencies. Please provide the contact information for your chief of staff/supervisor and subsequent release of information form below.

|                        |                      |            |                      |
|------------------------|----------------------|------------|----------------------|
| Surname                | <input type="text"/> |            |                      |
| Given name             | <input type="text"/> |            |                      |
| Street name and number | <input type="text"/> | Apt number | <input type="text"/> |
| City                   | <input type="text"/> | Province   | <input type="text"/> |
| Postal code            | <input type="text"/> |            |                      |
| Phone number           | <input type="text"/> | Fax number | <input type="text"/> |
| E-mail                 | <input type="text"/> |            |                      |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form B: Fees and payment details**  
**ANESTHESIOLOGY**

**Fees**

Please complete the attached credit card authorization form with applicable fees.

**Current assessment fees are as follows:** (please note a fee reduction of \$500 will apply to those who have previously had their training assessed by the Royal College):

**Note:** If you are unable to submit your application by the April 30 deadline due to not yet meeting the eligibility criteria for PER, please contact [per@royalcollege.ca](mailto:per@royalcollege.ca)

The eligibility criteria can be found on the Royal College website at [www.royalcollege.ca/per](http://www.royalcollege.ca/per)

| <b>Application date:</b>  | <b>Without fee reduction</b>           |
|---|--|
| <b>Before April 30 of the year before</b> you wish to be examined/assessed ( <i>basic assessment fee</i> )  | <b>\$3,930</b>                         |
| <b>Between May 1 and August 1 of the year before</b> you wish to be examined/assessed ( <i>basic assessment fee + applicable late penalty fee</i> ) | $\$3,930 + \$695 = \mathbf{\$4,625}$   |
| <b>After August 1 of the year before</b> you wish to be examined/assessed ( <i>basic assessment fee + applicable late penalty fee</i> )             | $\$3,930 + \$1,380 = \mathbf{\$5,310}$ |

| <b>Application date:</b>  | <b>With fee reduction</b>                      |
|---|--|
| <b>Before April 30 of the year before</b> you wish to be examined/assessed ( <i>basic assessment fee - fee reduction</i> )  | $\$3,930 - \$500 = \mathbf{\$3,430}$           |
| <b>Between May 1 and August 1 of the year before</b> you wish to be examined/assessed ( <i>basic assessment fee + applicable late penalty fee - fee reduction</i> ) | $\$3,930 + \$695 - \$500 = \mathbf{\$4,125}$   |
| <b>After August 1 of the year before</b> you wish to be examined/assessed ( <i>basic assessment fee + applicable late penalty fee - fee reduction</i> )             | $\$3,930 + \$1,380 - \$500 = \mathbf{\$4,810}$ |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form B: Fees and payment details**  
**ANESTHESIOLOGY**

|                     |   |
|---------------------|---|
| Date of application | <input style="width: 100%;" type="text"/> |
|---------------------|---|

**Credit card authorization**  
*One time use only*

|                     |   |   |  |
|---------------------|---|---|--|
| Name of applicant   | <input style="width: 100%;" type="text"/> |   |  |
| <b>Total amount</b> | <input style="width: 25%;" type="text"/>  | <b>**Please note:</b> The Royal College will charge the credit card in Canadian dollars |  |
| Card type           | <input type="radio"/> Mastercard          | <input type="radio"/> Visa  | <input type="radio"/> American Express |
| Card number         | <input style="width: 100%;" type="text"/> |   |  |
| Expiry date (mm/yy) | <input style="width: 100%;" type="text"/> |   |  |
| Cardholder's name   | <input style="width: 100%;" type="text"/> |   |  |

By clicking 'I agree', the Royal College is authorized to charge the non-refundable assessment fee to the credit card listed above for the total amount indicated.

**I Agree**

**Royal College use only**

|                | Financial Revenue Code(s)                 |   |  |
|----------------|---|---|--|
| Date           | <input style="width: 100%;" type="text"/> |   |  |
| ID number      | Code                                      | 332                                       | Amount <input style="width: 100%;" type="text"/> |
|                | Code                                      | <input style="width: 100%;" type="text"/> | Amount <input style="width: 100%;" type="text"/> |
|                | Code                                      | <input style="width: 100%;" type="text"/> | Amount <input style="width: 100%;" type="text"/> |
| Agent initials | <input style="width: 100%;" type="text"/> |   |  |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form C:** Declaration of understanding and release of information

**ANESTHESIOLOGY**

**Declaration of understanding & authorization for release of information**

**Identification**

|   |  |               |           |            |             |
|---|--|---------------|-----------|------------|-------------|
| Surname   |  |               |           |            |             |
| Middle name(s)  |  |               |           |            |             |
| Given name  |  | Date of birth |           |            |             |
|   |  |               | <i>DD</i> | <i>MMM</i> | <i>YYYY</i> |
| <i>Used only to confirm identity</i>                          |  |               |           |            |             |
| To  |  |               |           |            |             |
| <i>Name of applicant's Medical Regulatory Authority (MRA)</i> |  |               |           |            |             |
| Dated at  |  |               |           |            |             |
| <i>City and province</i>                                      |  |               |           |            |             |

**By providing my signature, I, the above-named physician, hereby agree to the following:**

**Release of information to your Medical Regulatory Authority (MRA)**

I agree that the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") may release and disclose any and all information to the Medical Regulatory Authority ("MRA") in the province or territory in which I hold a medical license and/or registration to practice medicine and other national regulatory authorities, relative to my training history, practice profile, credentialing and examination eligibility, examination and or assessment results including but not limited to my scope of practice description, eligibility details, summary of performance and any ongoing evaluations and outcome. The Royal College may provide to my MRA copies of any and all records in my file. This authorization shall continue until revoked by me in writing.

**Sharing of information between your current chief of staff and the Royal College**

I authorize the person I listed as my Chief of Staff/Supervisor on Form A to release any and all information which the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") may request relating to my training history, credentialing, and examination eligibility. I hereby authorize my chief of staff/supervisor to provide to the Royal College copies of any and all records in my file. This authorization shall continue until revoked by me in writing. A photo copy of this authorization shall serve in its stead.

**Declaration of understanding & authorization for release of information *cont'd***

**Consequences of False/Fraudulent Documentation and/or Irregular Behavior**

I agree to provide authentic and accurate information and documentation to the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") and to participate in good faith in the assessment process.

I understand that if I provide false/fraudulent documentation to the Royal College or engage in irregular behavior with respect to my assessment, my actions may lead to serious consequences as outlined below.

In the event (i) that any of my information submitted to the Royal College including personal information in any documents in support of my application, including my credentials, is determined or believed by the Royal College not to be authentic or to be false, fraudulent or otherwise deceptive, or (ii) that any such information related to the Royal College submitted to other agencies is determined or believed by them or the Royal College not to be authentic or to be false, fraudulent or otherwise deceptive, or (iii) of any irregular behavior, the Royal College may take appropriate action as it sees fit, including, but not limited to:

- Revoking my eligibility;
- Terminating my assessment and withholding or invalidating my assessment results;
- Barring me from any future Royal College examinations or other assessments; and
- Notifying each of the Canadian medical regulatory authorities, in addition to licensing, regulatory, educational, training, resident matching services, credentials verification authorities, hospitals, clinics and other medical facilities and organizations that utilize the services of physicians, government agencies (local, state, provincial, federal or foreign), law enforcement agencies or other third parties and organizations, and their representatives, who in the opinion of the Royal College have a legitimate interest in such information. I acknowledge that this notification or disclosure of information may occur regardless of whether or not I have withdrawn my consent to any other uses or disclosures of my information by the Royal College.

**Confidentiality agreement**

I undertake to respect the confidentiality of the assessment and acknowledge that I understand the following:

Failure to respect the confidentiality of the assessment may be deemed professional misconduct and my assessment results may be voided, and the Royal College of Physicians and Surgeons of Canada ("RC" or "Royal College") may notify Canadian licensing authorities of the situation.

That the examination and practice based assessment questions and scenarios are protected by copyright and are the exclusive property of the Royal College.

That any reproduction, dissemination or other disclosure of the assessment questions and or scenarios in whole or in part is strictly prohibited and that the Royal College may take all available disciplinary measures and legal actions against any candidate or others who violate this confidentiality provision including revocation of eligibility, cancellation of results and prohibition from any other Royal College examination/assessment.





## Practice Eligibility Route to Certification for Specialists (PER)

**Form C:** Declaration of understanding and release of information

**ANESTHESIOLOGY**

### Declaration of understanding & authorization for release of information *cont'd*

#### Release of information between Pivotal Research and the Royal College

I authorize the Royal College to release my contact\* information to:

Pivotal Research Inc. for the purposes of the completion of the Multisource Feedback surveys

#### Immunity and Release

I hereby extend absolute immunity to, and release, discharge and hold harmless from any and all liability:

- (1) Royal College and its respective employees, agents, representatives, members, directors and officers; (collectively known as the Royal College,) for or in respect of any acts, communications, reports, statements, documents, recommendations or disclosures involving me, made in good faith and without malice by the Royal College.

Limitation of Liability:

The Royal College's liability for damages in connection with the conduct of the assessment whether arising in contract (including fundamental breach), tort (including negligence), or otherwise, even if the Royal College has been advised of the possibility of such damages, shall not exceed the amount of the assessment fee paid by the candidate. In no event shall the Royal College be liable for any indirect, incidental or consequential damages of any kind regardless of the cause and whether arising in contract (including fundamental breach), tort (including negligence), or otherwise, even if the Royal College has been advised of the possibility of such damages and release:

**By providing my signature, I, the above-named physician, hereby acknowledge and agree to the Terms and Conditions listed above and consent to the disclosure of my personal information in accordance with those Terms and Conditions.**

|                          |  |
|--------------------------|--|
| Applicant name (printed) |  |
| Applicant signature      |  |
| Date                     |  |

|                        |  |
|------------------------|--|
| Witness name (printed) |  |
| Witness signature      |  |
| Date                   |  |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form D:** Current scope of practice

**ANESTHESIOLOGY**

**Definition of a scope of practice:**

1. Every physician's scope of practice is unique
2. A physician's scope of practice is determined by the patients the physician cares for, the procedures performed, the treatment provided, and the practice environment.
3. A physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgement, which are developed through training and experience in that scope of practice.

**Identification**

Surname

Given name

**1. How would you best describe your practice (e.g. general medicine, pain management, vascular surgery, etc.)?**

**2) In the chart below, 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*:**

| Practice settings                            | # patients seen per week | # hours spent in direct patient contact per week |
|--|--------------------------|--|
| <b>A. Office practice</b>                    |                          |  |
| <b>a) Private office</b>                     | <input type="text"/>     | <input type="text"/>                             |
| <b>b) Health services organization (HSO)</b> | <input type="text"/>     | <input type="text"/>                             |
| <b>c) Community health centre</b>            | <input type="text"/>     | <input type="text"/>                             |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form D:** Current scope of practice

**ANESTHESIOLOGY**

| Practice settings  | # patients seen per week | # hours spent in direct patient contact per week |
|--|--------------------------|--|
| <b>d) Walk-in clinic; after hours clinic; urgent care setting</b> (e.g. generally no appointments; generally episodic care; non-static patient base) |                          |  |
| <b>e) Academic teaching unit</b>   |                          |  |
| <b>B. Hospital</b>   |                          |  |
| <b>a) Community hospital</b>   |                          |  |
| Inpatients   |                          |  |
| Outpatients  |                          |  |
| Emergency  |                          |  |
| Surgical assist  |                          |  |
| Surgery  |                          |  |
| Hospitalist  |                          |  |
| <b>b) Academic/teaching hospital</b>   |                          |  |
| Inpatients   |                          |  |
| Outpatients  |                          |  |
| Emergency  |                          |  |
| Surgical assist  |                          |  |
| Surgery  |                          |  |
| Hospitalist  |                          |  |
| <b>C. Long-term care facility</b>  |                          |  |
| <b>a) Nursing/retirement home</b>  |                          |  |
| <b>b) Supportive housing/assisted living</b>   |                          |  |
| <b>D. Other (please specify)</b>   |                          |  |
|  |                          |  |
|  |                          |  |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form D:** Current scope of practice

**ANESTHESIOLOGY**

**3) In a typical week, please estimate to % of your patient contacts that fall within each of the following categories (please note that the TOTAL SHOULD EQUAL 100%):**

| For MEDICAL disciplines:   |  | % of patient visits |
|--|--|---------------------|
| <b>a) NEW CONSULTATIONS:</b><br><i>New patients of known patients presenting prior to medical procedures for pre-operative examinations, testing and treatment.</i>                          |  |                     |
| <b>b) FOLLOW UP CONSULTATIONS:</b>   |  |                     |
| <b>c) LONG-TERM FOLLOW UP:</b><br><i>Patients to whom you provide post-operative/post procedural care, which may include follow up of patients with conditions requiring long-term care.</i> |  |                     |
| <b>d) EMERGENCY MANAGEMENT:</b><br><i>Patients to whom you provide care for in the emergency department.</i>   |  |                     |
| <b>e) OTHER (please specify):</b>  |  |                     |
| <b>Total</b>   |  | <b>100%</b>         |

| For SURGICAL disciplines:  |  | % of patient visits |
|--|--|---------------------|
| <b>a) NEW CONSULTATIONS:</b><br><i>New patients of known patients presenting prior to medical procedures for pre-operative examinations, testing and treatment.</i>  |  |                     |
| <b>b) PRE-OPERATIVE ASSESSMENT MANAGEMENT:</b><br><i>Providing patients with intra-operative/procedural treatments.</i>  |  |                     |
| <b>c) OPERATIVE MANAGEMENT &amp; PROCEDURES:</b>   |  |                     |
| <b>d) POST-OPERATIVE MANAGEMENT AND FOLLOW-UP:</b><br><i>Patients to whom you provide post-operative/post procedural care, which may include follow up of patients with conditions requiring long-term care.</i> |  |                     |
| <b>e) EMERGENCY MANAGEMENT:</b><br><i>Patients to whom you provide care for in the emergency department.</i>   |  |                     |
| <b>f) OTHER (please specify):</b>  |  |                     |
| <b>Total</b>   |  | <b>100%</b>         |

| <b>4) In the community in which you work, do you have:</b>   | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| <b>a) ACCESS TO BASIC LABORATORY SERVICES?</b><br><i>e.g. hemoglobin, urine, blood glucose analyses, etc.</i>              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>b) ACCESS TO ADVANCED LABORATORY SERVICES?</b><br><i>e.g. bone density, cardiac stress test, electromyography, etc.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>c) ACCESS TO BASIC RADIOLOGICAL SERVICES?</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>d) ACCESS TO CT OR MRI?</b><br><i>Access on site or within 30 minutes</i>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>e) ACCESS TO OTHER SPECIALISTS FOR REFERRAL OR CONSULTATION?</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>f) REGULAR CONTACT AND INTERACTION WITH PHYSICIANS IN THE SAME DISCIPLINE IN YOUR COMMUNITY?</b>                        | <input type="checkbox"/> | <input type="checkbox"/> |

**Practice Eligibility Route to Certification for Specialists (PER)**

**Form D:** Current scope of practice

**ANESTHESIOLOGY**

**5) Please list a minimum of 10 of the most common conditions/diseases/procedures that you CURRENTLY see/perform in your practice.**

|     |  |
|-----|--|
| 1.  |  |
| 2.  |  |
| 3.  |  |
| 4.  |  |
| 5.  |  |
| 6.  |  |
| 7.  |  |
| 8.  |  |
| 9.  |  |
| 10. |  |
| 11. |  |
| 12. |  |
| 13. |  |
| 14. |  |
| 15. |  |
| 16. |  |
| 17. |  |

**6) Training and previous practice experience:**

**a.** Briefly describe your training in Anesthesiology: duration, caseload, training setting, exposure to subspecialty Anesthesiology:

**b.** Did you complete all of the necessary training and any examination and/or fellowship necessary to qualify as an independent specialist Anesthesiologist in your country of training? *If no please describe.*



**8) Current practice environment:**

**a. Community Size**

**b. Hospital size and type (academic, urban community, rural)**

**c. Nearest referral centre**

**d. Surgical services supported**

**e. Obstetrical experience in your hospital (number of deliveries, percentage of operative deliveries, percentage of epidural labor analgesia)**

**9) Current practice:**

**a. Are there any services provided by your department of Anesthesiology that you do not participate in? *If yes, please describe:***

**b. Do you participate in non-hospital based practice? *If yes, please describe:***