ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

# Practice Eligibility Route to Certification for Subspecialists (PER-sub)

GERIATRIC PSYCHIATRY

## Application for Practice Eligibility Route to Certification for Subspecialists (PER-sub)

Candidates pursuing this route to the subspecialty examination must meet the eligibility criteria & belong to one of the two cohorts.

### Eligibility Criteria

a. Royal College certification in a primary specialty that is the entry route to the subspecialty

b. Proof of a valid, unrestricted license to practice in Canada

c. A scope of practice that meets the criteria set out by and acceptable to the discipline's specialty committee

d. Attestation by 2 referees of the physician's scope and quality of his/her practice

e. Registration in the Royal College Maintenance of Certification Program (MOC)

### Cohort 1

a. At the time of applying applicants must be in practice for a minimum of 5 years in Canada in the subspecialty
   - The last two years of practice must have been in a continuous practice location in Canada
   - Those who completed Psychiatry training in 2012 or later must provide documentation of 24 months of unaccredited training in the subspecialty of Geriatric Psychiatry

### Cohort 2

a. At the time of applying applicants must be in practice for a minimum of 1 year and a maximum of 5 years in Canada in the subspecialty
   - A minimum of one year must be in a continuous practice location

b. Confirmation of successful completion of <u>at least one</u> of the following:
   - Two years of unaccredited training in Geriatric Psychiatry in Canada that was completed prior to June 30, 2016. Training must be registered with a Canadian university postgraduate medical education office.
     ***OR***
   - Proof of ACGME accredited training that is equivalent in length to the requirements as set out in the subspecialty's Specialty Training Requirements (STR).

**Contact the Credentials Unit if a leave of absence was taken delaying the end-of-training date.**

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GERIATRIC PSYCHIATRY

| PLEASE SEND YOUR COMPLETED FORMS TO: | |
|---|---|
| **Postal address:**<br>Royal College of Physicians and Surgeons of Canada<br>Credentials Unit<br>774 Echo Drive<br>Ottawa, ON<br>K1S 5N8 | **Email:** persub@royalcollege.ca<br><br>**Fax:** 613-730-3707 |

| PLEASE ATTACH THE FOLLOWING DOCUMENTS TO YOUR APPLICATION: | |
|---|---|
| ☐ | **Copy of your CV** |
| ☐ | **Proof of licensure in a Canadian province** |
| ☐ | **Proof of training in Geriatric Psychiatry as well as details of the training rotations** (for those applying through cohort 2) |

**IMPORTANT INFORMATION:**

- The **deadline** to submit your application for certification via the Practice Eligibility Route for Subspecialists is August 31st of the year before you wish to be examined.
  - Click here for a list of current assessment fees
  - Should you submit your application after the deadline, you will be subject to a non-refundable late penalty fee

- Please ensure that you have reviewed the criteria before submitting your application

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**Route: Practice Eligibility Route to**

**Form A: PERSONAL DETAILS**

**IMPORTANT NOTES**

- You will receive email confirmation that your application has been received.
- The Royal College will remain in contact with you via email. Please ensure that we have your current email address on file.
- Applications will be reviewed in the sequence in which they are received. This process will take several months.
- You will be contacted directly if we require any additional information.

| **Subspecialty:**_____ | **Exam Year:** _____ |
|---|---|

## PERSONAL DETAILS

### 1. Identification

| Title: ☐ Dr. ☐ Dr ☐ Dre | Sex: ☐ Male ☐ Female |
|---|---|
| Language: ☐ English ☐ French | Date of Birth: __ __ / __ __ / __ __ (DD MM YY) |
| Surname: | |
| Given Name: | Middle Name: |
| Royal College ID (if applicable): | |

### 2. Contact Information

☐ Home Address ☐ Business Address

| Street no. and name: | | Apt no: |
|---|---|---|
| City: | Province: | Postal Code: |
| ☐ Home phone ☐ Business phone ☐ Cell phone | | ☐ Home phone ☐ Business phone ☐ Cell phone |
| ☐ Home email ☐ Business email | | ☐ Home email ☐ Business email |

**CONTACT INFORMATION**

Web: www.royalcollege.ca
Phone: 1-800-267-2320
Fax: 613-730-3707
Email: persub@royalcollege.ca

Mail: 774 Echo Drive
Ottawa, ON
K1S 5N8

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**Form B: CREDIT CARD AUTHORIZATION FORM**

# CREDIT CARD AUTHORIZATION FORM

***ONE TIME USE ONLY***

*I authorize the Royal college to charge the non-refundable assessment fee to my credit card for the amount indicated.*

NAME OF APPLICANT:_____
(PLEASE PRINT)

Amount $ [ ]

Mastercard _____ Visa_____ American Express_____

Card Number:_____

Expiry Date (MM/YY): _____ / _____

Cardholder's name:

_____
(PRINT CLEARLY)

Cardholder's signature:

[ ]

**Please note:The Royal College will charge the credit card in Canadian dollars.

**Royal College use only**

ID number: _____

Specialty Name :_____

Specialty Code: _____

Financial Rev Code: _____

Agent initials: _____

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|---|---|
| **Route: for** | **Practice Eligibility Route to Certification Subspecialists (PER-sub)** |
| **Form C:** | **DECLARATION** |

## DECLARATION – FORM C

All personal, biographical and academic information relating to your training is confidential and is provided for the recognized legitimate use by the officers and staff of the Royal College.

The Royal College may receive and exchange any and all information, which may be requested relative to my training history, credentialing, examination eligibility, scope and competencies in practice from my Chief of Staff, Head of Department or any other supervisor to whom I report in a Canadian institution; the Medical Regulatory Authority in the Canadian province in which I practice; and any and all institutions where I undertook my postgraduate medical education training.

I understand that any misinformation in this application or in any document at any time, provided by me in support of my application, may lead to refusal of my application or withdrawal of eligibility previously granted.

I agree to abide by the decisions of the Royal College of Physicians and Surgeons of Canada.

Signature _____ Date _____

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|---|---|
| **Route:** | **Practice Eligibility Route to Certification for Subspecialists (PER-sub)** |
| **Form D:** | **SCOPE OF PRACTICE – Geriatric Psychiatry** |

**DEFINITION OF A SCOPE OF PRACTICE:**

i) Every physician's scope of practice is unique.
ii) 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.
iii) A physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgment, which are developed through training and experience in that scope of practice.

| **Identification:** | |
|---|---|
| Surname: | |
| Given name: | |
| 1. How many years have you been practicing Geriatric Psychiatry? | |
| 2. How many hours per week do you spend in Geriatric Psychiatry activities? For applicants who spend less than 50% of their current practice time in Geriatric Psychiatry, please submit an explanation of the nature and percentage of practice time currently devoted to Geriatric Psychiatry. | |
| | |
| 3. Describe your practice/involvement in Geriatric Psychiatry in each of the following categories. Please provide sufficient detail so assessors can interpret the nature of your subspecialty activities. | |
| **i. Patient care (direct and indirect). Please describe your practice setting(s) and the 10 most common conditions/disorders/diseases seen in each.** | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |
| 9. | |
| 10. | |

| **ii. Teaching/Education** |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |
| **iii. Administration** |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |

| **iv. Research/Scholarly Activities** |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |
| **v. Advocacy/Policy and Public Health/Community, Service or System Development** |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |

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|---|---|
| **Route:** | **Practice Eligibility Route to Certification for Subspecialists (PER-sub)** |
| **Form E:** | **REFEREE VERIFICATION (RV) – Geriatric Psychiatry** |

Please provide the names of individuals who have knowledge of your professional practice. They will be contacted and asked to provide feedback on your practice. (*i.e.: chief of staff, head of department etc…*)
***A release of information form for each of your referees must be appended to this form (see Form F).***

| **Applicant Identification:** |
|---|
| Surname: |
| Given name: |

## A: Identification of Referee #1

☐ **GERIATRIC PSYCHIATRIST** (Preferable)

**Title/ Position:** ☐ Dr. ☐ Dr ☐ Dre

**Name:**

**Contact Information for Referee #1**

| Street no. and name | | Apt no. | |
|---|---|---|---|
| City | Province | Country | Postal Code |
| Telephone ext.( ) | Fax | E-mail | |

## B: Identification of Referee #2

**Title/ Position:** ☐ Dr. ☐ Dr ☐ Dre

**Name:**

**Contact Information for Referee #2**

| Street no. and name | | Apt no. | |
|---|---|---|---|
| City | Province | Country | Postal Code |
| Telephone ext.( ) | Fax | E-mail | |

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**Form F: RELEASE OF INFORMATION FOR REFEREE**

## AUTHORIZATION FOR RELEASE OF INFORMATION FOR REFEREE

**From:** _____

**Please print your name**

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

**I, THE ABOVE-NAMED PHYSICIAN, HEREBY AUTHORIZE:**

_____

**Name of Referee**

To release any and all information which may be requested relative to my training history, credentialing and examination eligibility. You may furnish copies of any and all records in my file. This authorization shall continue until revoked by me in writing. A photocopy of this authorization shall serve in its stead.

**Dated at:** _____

**City and Province / Territory**

**Dated:** _____

**(Day)** **(Month and Year)**

_____ _____

**Applicant's signature** **Applicant's name**

_____ _____

**Witness signature** **Witness' name**

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**Form G: PRACTICE AND TRAINING DETAILS**

| **Identification:** | | |
|---|---|---|
| Surname: | | |
| Given name: | | |
| **CURRENT PRACTICE DETAILS** | | |
| Subspecialty: | | |
| What date did you start practicing in the subspecialty listed above: __ __ / __ __<br>*Do not include fellowship training* MM YY | | |
| What date did you start practicing in the subspecialty in Canada: __ __ / __ __<br>MM YY | | |
| What percentage of time do you spend practicing the in the subspecialty listed above: _____% | | |
| Additional Comments: | | |
| **POSTGRADUATE MEDICAL EDUCATION HISTORY**<br>*Only complete if you have less than five years in practice.* | | |
| Training in the subspecialty of: | | |
| ☐ Residency ☐ Fellowship ☐ Other *(please specify):* | | |
| Start of training date: | End of Training date: | Total # months = |
| Name of institution: | | |
| ***Attach proof of completion of training document (e.g. diploma, transcript)*** | | |
| *Any additional training/experience relevant to the subspecialty:* | | |
| Training in the subspecialty of: | | |
| Residency ☐ Fellowship ☐ Other ☐ *(please specify):* | | |
| Start of training date: | End of Training date: | Total # months = |
| Name of institution: | | |
| ***Attach proof of completion of training document (e.g. diploma, transcript)*** | | |

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## CURRICULUM VITAE (CV) – Cover Page

*Please attach your Curriculum Vitae (CV) behind this cover page

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## Provincial License – Cover Page

*Please attach a copy of your license to practice behind this cover page

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## Documentation of Subspecialty Training – Cover Page

*If you have been in subspecialty practice for less than 5 years, please attach official documentation of your subspecialty training behind this cover page