BC Colposcopy Certification Application

Name:	Date:
Contact Address:	Contact Email:
Contact Phone Number:	

Medical School:	Year Completed:
Residency Program:	Year Completed:
FRCSC	Year obtained:
Current Hospital Staff Appointment:	Appointment date:
Current Hospital Staff Appointment:	Appointment date:

Please describe any previous Colposcopy training and/or experience you have had:

Please provide the name of a reference of the clinical supervisor for this training:

Please list any CME Colposcopy Courses completed:

Date	Title	Institution (eg. ASCCP)

Please list your membership in any relevant professional societies: (eg. ASCCP)

Where are you planning on practicing Colpscopy in B?

Is this a BCCA Affiliated Clinic located in a hospital?

Do you have a Colposcopist in your clinic that is willing to supervise your training?

If so, please provide name and contact details:

When are you planning on starting?

Is there sufficient existing sessional support (Alternative Payment System) for this Colpsocopy Clinic?

If not, are you planning on billing through the Medical Services Plan or applying for additional sessions?