



Application to Provide Complementary and Alternative Medicine

A. Personal Identification

Name: _____

CPSA Registration #: _____

Mailing Address: _____

Location of Practice _____

(if different than above): _____

Business Phone No: _____ Business Fax No: _____

Type of Practice: Family:

Specialty: Type: _____

B: Description of Complementary and Alternative Medicine

I intend to offer the following complementary and alternative medicine in my medical practice (list the names of the therapies that meet the definition below:

I intend to employ the following agents, methodologies and/or drugs:

Methodology / Agent

Indications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C. Education

For each methodology, agent or category of complementary and alternative medicine, attach the following description of postgraduate education taken:

1. sponsoring organization
2. location
3. dates
4. description of method of instruction (didactic and/or practical
5. method of evaluation of learner
6. certification granted (including name of organization)
7. qualifications of instructors
8. other continuing education taken in the modality or use of agent

D. Recognition of Complementary and Alternative Medicine

For each methodology, agent or category of complementary and alternative medicine, describe the following:

1. Standards of practice established for its use.
2. Recognition by regulatory authorities or the World Health Organization.
3. Status of the drug, agent or device with Health Canada or the Food & Drug Administration (U.S.A.) for use in humans.

E. Evidence of Effectiveness

For each methodology or agent, attach a description of the evidence supporting its use for the indication(s) chosen.

F. Declaration

If approved to provide the aforementioned therapies, I agree to comply with the following Standards of Practice:

- (1) In this standard, Complementary and Alternative Medicine (hereafter referred to as "CAM") means a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine.
 - (a) While some scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well designed scientific studies. These questions include whether these therapies are safe and whether they are effective for the diseases or medical conditions for which they are used.
 - (b) The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional healthcare and as new approaches to healthcare emerge.
- (2) A physician must not provide a CAM therapy to a patient until the physician has been approved by the Registrar to provide such therapy.
- (3) Application for approval to provide CAM therapy must provide information about the therapy and the physician's training and experience with the therapy, acceptable to the Registrar.
- (4) A physician does not require approval from the Registrar to provide medical information to support a patient's application to possess dried marihuana pursuant to the federal Marihuana Medical Access Regulations.

- (5) Where it is uncertain whether the use of nutritional supplements, vitamins, pharmaceuticals or natural health products approved by Health Canada, or physical therapies are CAM therapies, those which are supported by scientific studies published in orthodox medical literature do not require application for approval from the Registrar.
- (6) Notwithstanding subsection (2), a physician who does not hold approval to administer a CAM therapy may provide the CAM therapy without approval from the Registrar to a patient who suffers from a fatal, incurable disease provided that the steps set out in subsection (7) are followed.
- (7) A physician who provides a CAM therapy to a patient must ensure that the following steps have been fulfilled:
 - (a) an orthodox medical evaluation of the patient, which must include the taking of an appropriate history, conducting an appropriate physical examination and conducting the appropriate diagnostic tests or investigations, as are relevant to the patient's complaint, presenting condition and history,
 - (b) an orthodox medical diagnosis has been established,
 - (c) orthodox medical treatment options have been discussed with the patient,
 - (d) the unproven status, the safety and the potential toxicity of the CAM therapy have been discussed with the patient,
 - (e) the physician's professional experience with the use of the CAM therapy and conventional therapy has been declared to the patient; and
 - (f) the number of treatments, time frame and costs to the patient for the CAM therapy are discussed with the patient.
- (8) A physician must keep a medical record that documents completion of the steps in section (7).
- (9) A physician conducting clinical research into the use of a CAM therapy must have approval for the research from an approved ethics review board.

Practitioner's Signature

Date

G. Application Fee

- I have enclosed a signed cheque in the amount of \$200.00 + GST
- I have provided my Credit Card information on the attached form and approve the College to charge me \$200.00 + GST.

Practitioner's Signature

Date

Additional comments may be included on the following page.

Please forward your application to:

Quality of Care Department - Registrar Approvals
 College of Physicians & Surgeons of Alberta
 2700, 10020 - 100 Street NW
 Edmonton AB T5J 0N3

Email: tanya.wicks@cpsa.ab.ca / Phone: (780) 423-4764 / Toll Free: 1-800-320-8624 / Fax: (780) 428-2712



College of
Physicians
& Surgeons
of Alberta

2700 - 10020 100 Street NW
Edmonton, AB, Canada T5J 0N3

Credit Card Payment Form

\$200.00 + GST application fee for Complementary and Alternative Medicine application

Full Name: _____

CPSA Registration or CPSA Tracking Number: _____

To pay by VISA, MasterCard or American Express complete and forward the following information to the College of Physicians & Surgeons of Alberta:

- VISA
- MasterCard
- American Express

Card Number: _____

Expiry Date (MM/YY): _____

Cardholder Name (Please Print): _____

Cardholder Signature: _____

Please note that this form and information will be destroyed 60 days following receipt.