



2020/21 Medical Staff Reappointment Application

*****Save this form onto your computer and then open the downloaded form BEFORE beginning*****

NAME

DEPARTMENT: CHOOSE ONE

CPSO or RCDSO #

DIVISION: Ophthalmology

CMPA #

CURRENT STATUS:

REQUESTED STATUS: No Change

1. All sections must be completed; reappointment form will be returned to you if missing information.
2. Failure to return this application will be considered an indication that you do not wish to have your hospital privileges renewed.
3. Complete applications must be submitted to your chief by **November 1, 2019**. Mandatory training must be completed by **November 1, 2019**.
 - o I hereby apply for reappointment to the Medical Staff of the Children's Hospital of Eastern Ontario-Ontario Children's Treatment Centre (CHEO) for the year ending March 31, 2021.
 - o I recognize that reappointment to the CHEO Medical Staff is governed by the CHEO Medical By-law and other applicable legislation including the Rules and Regulations and Policies and Procedures of the Hospital, the Public Hospitals Act of Ontario and the Regulations under the Public Hospital Act.
 - o If reappointed, and in consideration of such reappointment, I agree and undertake to conform and govern myself in accordance with all such relevant legislation, and to be bound by all existing and subsequent By-laws, Rules and Regulations, and Policies and Procedures that may be enacted from time to time.
 - o I hereby undertake to perform my professional work in a satisfactory manner and within the limits of privileges granted by the Board of Trustees of CHEO.
 - o I also undertake to maintain acceptable clinical standards in my area of practice.
 - o CHEO may, from time to time, request and receive information regarding the current status of my license from the College of Physicians and Surgeons of Ontario (CPSO) or the Royal College of Dental Surgeons (RCDSO) of Ontario.
 - o I will inform my Department/Division Chief, before submitting this reappointment form, if I am the subject of an investigation by the Discipline Committee or have been referred to the Complaints Committee of the CPSO, RCDSO or the equivalent body of any other province or country.
 - o I agree to the sharing of information pertaining to any concern that would be relevant to my practice, including professionalism, between those institutions where I hold privileges or appointment. If I am affiliated or hold an appointment with the University of Ottawa, I also agree to the sharing of information with this Institution.
 - o I declare and warrant that the information contained in this application is correct to the best of my knowledge. I also hereby authorize and covenant to the Hospital inquiring and confirming the information within.

I have read and agree with the above. Applicant's Initials:



2020-21 Medical Staff Reappointment Application

A. REAPPOINTMENT REQUEST:

PRIMARY HOSPITAL APPOINTMENT: CHEO OTHER*
Please indicate all other hospitals where you have privileges: *Please indicate your primary

TOH Bruyere The ROH Queensway Carleton Montfort
Other(s) please list:

At CHEO:

I WISH TO BE REAPPOINTED WITH THE SAME STATUS AS LISTED ON PAGE 1

OR

I WISH TO REQUEST A CHANGE IN STATUS TO WHAT I INDICATED ON PAGE 1

OR

I DO NOT WISH TO BE REAPPOINTED REASON:

If you are requesting to change divisions please indicate below - otherwise leave blank.
(Dept and Div Chief signatures required in Section Q)

From Division of:

To Division of:

If you are requesting to be cross appointed to another department and/or division at CHEO please specify the division below. Your primary division/department appointment will be what you indicated on page 1. If not, leave blank.

Cross Appointment to Division of:

B. MANDATORY TRAINING REQUIREMENT:

Select one of the following:

1. ACTIVE or ASSOCIATE status at CHEO (CHEO is your primary hospital) you are required to complete CHEO's mandatory training and provide a copy of your mandatory training report with your reappointment form from the CHEO onlinelearningcentre OR You have been informed that you need to complete CHEO mandatory training.

I certify that I have completed my mandatory training at CHEO and have attached my record of training.

2. Your PRIMARY hospital appointment is not CHEO but at another Champlain region hospital . Your training compliance confirmation will be sent from your primary hospital.

I certify that I have completed my mandatory training where I am primarily appointed.

3. COURTESY privileges at CHEO (you do not provide any direct patient care at CHEO) then you are not required to complete mandatory hospital training.

I have COURTESY privileges and do not provide any direct patient care at CHEO - mandatory training exempt



C. GENERAL INFORMATION:

Please choose Yes or No for each question below. **FOR EVERY YES ANSWER BELOW**, please attach a comprehensive explanation to the application and identify the licensing authority, health care facility, attending physician, other institution or persons involved in the situation.

1. Do you have any significant physical or behavioral impairment (including an addiction or substance use problem) which might affect your skills, attitude or judgement in the delivery of patient care?

NO YES

2. In the last year, has your license to practice, certificate of registration or permit to practice been suspended, restricted or revoked in any jurisdiction?

NO YES

3. In the last year, have you voluntarily surrendered your license, certificate of registration or permit to practice for any reason in any jurisdiction other than avoidance of the renewal fee?

NO YES

4. In the last year, have you been the subject of an adverse decision or disciplinary action by a professional licensing authority relating to your professional conduct, competence, capacity, or any other aspect of your practice in any jurisdiction?

NO YES

5. In the last year, have you been charged with, and/or found guilty of, any offence in Canada or elsewhere? (Include all offences under the Criminal Code of Canada, the controlled Drugs and Substances Act, the Food and Drugs Act, the Health Insurance Act, and/or related legislation in any province or jurisdiction. In addition, include any other offences related to the practice of medicine.)

NO YES



2020-21 Medical Staff Reappointment Application

6. In the last year, has a court made a finding against you in any lawsuit involving a patient or someone acting on behalf of a patient?

NO YES

7. In the last year, have you made a settlement of any lawsuit involving a patient or someone acting on behalf of a patient?

NO YES

8. In the last year, have you had your privileges suspended, revoked, reduced or denied in any jurisdiction?

NO YES

9. Are there any disciplinary actions pending against you by any professional licensing authority?

NO YES

10. In the last year, have you voluntarily relinquished your privileges during or as a result of an investigation in any jurisdiction?

NO YES

11. In the last year, have your privileges to prescribe narcotics or controlled drugs been suspended in any jurisdiction?

NO YES

12. In your practice, do you:

i. perform, assist in performing, or have the potential to perform exposure prone procedures as defined in the Blood Borne Pathogens policy?

NO YES***

OR

ii. perform or assist in performing procedures that may become exposure prone (e.g. laparoscopic that may convert to an open procedure)?

NO YES***

*** If you answered YES to either above, have you undergone appropriate testing to confirm your negative serologic status for blood borne pathogens, in compliance with the CPSO requirements?

NO YES



D. PROFESSIONAL ACTIVITIES and REVIEW (January 2018 to present):

I will be completing a formal uOttawa Physician Academic Review (PAR) for January 2018 to present. YES NO

Please note: if you answered YES above you can move to section E.

If you will not complete a PAR for January 2018 to present, PLEASE COMPLETE items 1 – 4 below.

You may copy and paste pertinent sections from another source. Do not attach your entire C.V.

Summary of professional activities to cover the period January 2018 to present:

1. CME courses attended (include number of hours)



2. Teaching activities (include number of hours):

3. Scientific publications and presentations:

4. Leadership role(s) and training:



2020-21 Medical Staff Reappointment Application

E. LIABILITY INSURANCE:

I have current liability insurance coverage appropriate to my level of practice through:

CMPA (Canadian Medical Protective Association)

RCDSO (Royal College of Dental Surgeons of Ontario)

N/A (not applicable)

F. I AM A MEMBER IN GOOD STANDING WITH THE CPSO/ RCDSO:

YES

NO

N/A

G. AUTHORIZATION:

I authorize CHEO to contact the CMPA, CPSO and/or RCDSO to verify my status with these organizations with respect to my reappointment application.

H. PRACTICE PROFILE - Collected for broad Health Human Resource planning purposes only:

Please provide information with regards to any anticipated change to your practice profile over the next 5 years. If no change is anticipated at this time, please type "no change."

I. LANGUAGE:

I am proficient in the following languages:

English

French

Other Language(s):

I have the CHEO FR/EN Bilingual designation

J. OCCUPATIONAL HEALTH:

NOTE: Courtesy members of the medical staff DO NOT need to comply with Occ Health Surveillance Program. Consulting members must be in compliance at their primary hospital.

I am in compliance with the Occupational Health's Communicable Disease Surveillance Program. If you have questions regarding your compliance please contact Occupational Health.



2020-21 Medical Staff Reappointment Application

K. CONTACT UPDATES:

If your address, phone number(s) or emergency contact information **has changed in the past year** please provide the updated information. If not, PLEASE LEAVE BLANK.

Address

City

Province

Postal Code

Primary Phone:

Alt phone:

Pager:

EMERGENCY CONTACT:

Last name

First name

Relationship

Phone number

L. PQII - Physician Quality Improvement Initiative - results do not influence reappointment:

I participated in the Physician Quality Improvement Initiative (PQII) Evaluation this past year.

YES

NO

If yes, I have met with my division or department chief to discuss the PQII.

YES

NO

M. CORPORATE MEDICAL DIRECTIVE ACKNOWLEDGEMENT:

I am an Associate, Active or Consulting CHEO physician with inpatient admitting privileges and my patients are over 12 yrs old. I acknowledge reviewing the medical directive below and agree that my patients will receive care outlined in the directive.

[#2112 Nursing consultation of BNCL Service/Psychiatry on-call for a positive ASQ score](#)

I AGREE

OR

This directive does not apply to me.

N. DECLARATION:

By initialing, I declare that all of the information contained in this reappointment application is up to date and accurate.



O. PAYMENT:

Please make payment online [here](#) on or before **November 1st** to avoid additional administration charges of \$180.

I have paid the Dues indicated below on (mm/dd/yyyy)

Name on card:

Payment was made in the amount of:

- Active \$120
- Associate - \$120 (First 3 years of primary appointment at CHEO)
- Consulting - \$45
- Courtesy - \$45

ATTENTION! COURTESY and CONSULTING MEDICAL STAFF:

Courtesy staff: An annual review meeting is not required.

Consulting staff: Your annual review meeting will occur at your primary hospital. A review meeting may still be schedule at the discretion of your CHEO Division or Department Chief.

To expedite finalizing your reappointment and signature process Consulting and Courtesy staff **please sign below.**

Signature: * by returning this form electronically via email with a typed "signature" I confirm its authenticity and validity.

* Reappointment Applicant
(Consulting or Courtesy Status)

Date

ACTIVE and ASSOCIATE STAFF: You will complete and sign this form at your annual meeting. (Section T)

**This is the end of PART 1.
Please follow the steps below to submit your 2019-20 form:**

1. Right click to save this form with your name in the title.
2. Send an email to your Division or Department Admin containing:
 - a. This form, with your name in the subject, to the administrative professional specified in the reappointment e-mail you received.
 - b. Include your proof of mandatory training.
3. Your Admin will schedule your annual review with your Division or Department Chief where you will complete Part 2 of this form and sign off. Your admin will submit to the Medical Staff Office.



PART 2 - Department or Division Chief to complete

P. ASSESSMENT OF APPLICANT’S PERFORMANCE OVER THE PAST YEAR:

- | | | | | | |
|----|--|--------------|-------------------|----------------|---------------------------|
| 1. | Quality of care and/or service work: | Satisfactory | Needs Improvement | Unsatisfactory | N/A |
| 2. | Participation in Departmental/Divisional activities: | Satisfactory | Needs Improvement | Unsatisfactory | N/A |
| 3. | Contributions to teaching: | Satisfactory | Needs Improvement | Unsatisfactory | N/A |
| 4. | Contributions to research: | Satisfactory | Needs Improvement | Unsatisfactory | N/A |
| 5. | Contributions to administrative activities, safety & quality improvements projects, other: | Satisfactory | Needs Improvement | Unsatisfactory | N/A |
| 6. | Completion of clinical records: | Satisfactory | Needs Improvement | Unsatisfactory | <input type="radio"/> N/A |
| 7. | Professional attitude and behavior: | Satisfactory | Needs Improvement | Unsatisfactory | <input type="radio"/> N/A |
| 8. | Communication and interpersonal skills: | Satisfactory | Needs Improvement | Unsatisfactory | <input type="radio"/> N/A |

The department/division chief **MUST** discuss with the applicant to review any concerns expressed in items 1-8 during the annual review; the content of the discussion must be documented below:



2020-21 Medical Staff Reappointment Application

Q. Goals and objectives

All **Active** and **Associate** staff must meet with their Department/Division Chief at least annually to discuss their goals and objectives for the coming year (if documented elsewhere, please attach documentation). List below 3 career objectives the individual will work towards during the next year.

R. Recommend for reappointment as requested:

YES

YES with restrictions, conditions, or areas requiring monitoring. Attach details

NO

For **ASSOCIATE** to **ACTIVE** status change:

Attach "Request for Medical Staff Category Change Associate to Active" form with reappointment form.

Found [HERE](#)

S. Division Change Request:

If requesting a division change you will need to have approval from both the division and department chiefs.

Current Division Chief Approval YES

Initial:

New Division Chief Approval YES

Initial:

Current Dept Chief Approval YES

New Dept Chief Approval YES

Comments:

T. SIGNATURES - Chiefs: Inform your Admin Professional that this form is ready to be printed and signed.

Date of Annual Review/PAR mtng:

Who attended the review mtng:

Signatures:

Reappointment Applicant

Date

Division Chief

Date

Department Chief

Date

Chief of Staff (Dept Chief only)

Date