ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

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

PAIN MEDICINE

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

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 completion of 24 months of training in Pain Medicine. Training must be:
   - Registered with a Canadian university postgraduate medical education office. Any unaccredited training must be completed by June 30, 2019.
     OR
   - ACGME accredited

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

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PAIN MEDICINE

PLEASE SEND YOUR COMPLETED FORMS TO:	
Postal address: Royal College of Physicians and Surgeons of Canada Credentials Unit 774 Echo Drive Ottawa, ON K1S 5N8	**Email:** persub@royalcollege.ca **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 Pain Medicine 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 Certification for Subspecialists (PER-sub)**

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

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

Route:	**Practice Eligibility Route to Certification for Subspecialists (PER-sub)**
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: _____

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

Route:	**Practice Eligibility Route to Certification for 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 _____

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

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

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.

Royal College use only:	Royal College ID:
Identification:	
Surname:	
Given name:	
1. How many years have you been practicing in your primary specialty?	
2. How many years have you been practicing in Pain Medicine ?	
3. How would you best describe your practice of Pain Medicine in a typical month?	
a) What are the number of hours you spend per month in direct patient contact related to Pain Medicine (education/research/scholarly activity/advocacy)?	
b) How many new consults in Pain Medicine have you seen in the past year?	
c) How many follow-up assessments in Pain Medicine have you seen in the past year?	

d) What are the ten most common diagnoses you have seen in the past year? Provide an estimated breakdown as a percentage of total number of patients seen. Please choose from the *attached list of common pain syndromes. If you commonly assess patients with a particular diagnosis that is not included in this list, provide details.

Diagnosis	% of total number of patients seen
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

e) List up to ten procedures that you commonly perform? Provide an estimated breakdown as a percentage of total number of procedures done.
If you do not perform any procedures, state not applicable.

Procedure	% of total number of procedures done
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

f) Please describe how your practice allows for interdisciplinary collaboration on patients with complex pain problems?

4. Briefly describe your practice/involvement in Pain Medicine over the past five years in each of the following categories:

a) Patient care (direct and indirect)

Practice setting:	List Allied Health discipline support at this site
i) Private Office	
ii) Community Clinic/Health Centre	
iii) Academic teaching Unit	
iv) Other	

b) Please describe your involvement in Education/Teaching, including patient education related to Pain Medicine over the past five years:
c) Please describe your involvement in Administration related to Pain Medicine over the past five years:
d) Please describe your involvement in Research/Scholarly activities related to Pain Medicine over the past five years :
e) Please describe your involvement in Advocacy/Policy and Public Health related to Pain Medicine :

*List of common pain syndromes for item 3.d).

NON-CANCER PAIN SYNDROMES

Somatic/mixed Pain
Chronic Headache
Whiplash-Associated Disorder
Cervical Degenerative Disc Disease
Shoulder Pain
Mechanical Low Back Pain
Failed Back Surgery Syndrome
Acute/Chronic Disc Herniation
Regional Myofascial Pain/Soft Tissue Rheumatism
Chronic/Recurrent Abdominal Pain
Chronic Pelvic Pain
Fibromyalgia Syndrome
Arthritis-Inflammatory and Osteoarthritis

Neuropathic Pain

Trigeminal Neuralgia
Post-herpetic Neuralgia
Painful Peripheral Neuropathy
Complex Regional Pain Syndrome Types 1 and 2
Post-Surgical Pain Syndromes (thoracotomy, mastectomy, hernia, joint replacement)
Peripheral Nerve Entrapments
Post-spinal cord injury pain
Phantom Pain

CANCER PAIN SYNDROMES

Bone Metastases (Spine)
Brachial or Lumbosacral Plexopathies
Chemotherapy-induced peripheral neuropathies
Visceral Pain

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

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. At least one physician referee must be a Department Chair/Chief or supervisor.
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

Title/ Position: ☐ Dr. ☐ Dr ☐ Dre

Name:

Contact Information for Referee #1

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

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Route:	**Practice Eligibility Route to Certification for Subspecialists (PER-sub)**
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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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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Route: **Practice Eligibility Route to Certification for Subspecialists (PER-Sub)**

Form G: **PRACTICE & TRAINING DETAILS**

Identification:		
Surname:		
Given name:		
CURRENT PRACTICE DETAILS		
Subspecialty:		
What date did you start practicing in the subspecialty listed above: __ __ / __ __ *Do not include fellowship training* MM YY		
What date did you start practicing in the subspecialty in Canada: __ __ / __ __ MM YY		
What percentage of time do you spend practicing the in the subspecialty listed above: _____%		
Additional Comments:		
POSTGRADUATE MEDICAL EDUCATION HISTORY *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