

**APPLICATION  
FOR  
FACILITY ACCREDITATION**



**CBCPO  
CCCPO**

**Canadian Board for Certification  
of  
Prosthetists and Orthotists**

*Effective May 30, 1994*

**CANADIAN BOARD FOR CERTIFICATION  
OF PROSTHETISTS AND ORTHOTISTS ("C.B.C.P.O.")**

**APPLICATION FOR FACILITY ACCREDITATION**

**INSTRUCTIONS**

1. The enclosed booklet defines the requirements governing facility accreditation and should be read carefully before filling out this application.
2. Please type or print clearly.
3. Application fee of \$250.00 plus applicable taxes must accompany this initial or renewal application.
4. Any additional statements should be made on supplemental sheets to be attached to this form, and should show name of applicant.

All personal information provided in this Application shall be used by C.B.C.P.O. solely for the purpose of assessing the facility for accreditation, and if successful, C.B.C.P.O. shall use the personal information to monitor accreditation status. In any event, C.B.C.P.O. may keep a copy of this application on file. The personal information included in this application shall not be disclosed except where permitted or required by law. C.B.C.P.O. shall handle all personal information provided in accordance with its obligations at law pursuant to the *Personal Information Protection and Electronic Documents Act* and *Regulations* and in accordance with its Privacy Policy.

A complete copy of the C.B.C.P.O. Privacy Policy is available by contacting:

Kathy Kostycz, Privacy Officer  
Canadian Board for Certification of Prosthetists and Orthotists  
605-294 Portage Avenue, Winnipeg, Manitoba R3C 0B9  
Phone - 1 (204) 949-4970

- Note:*
1. Processing of applications usually requires a minimum of three months from filing of application.
  2. Any applicant not satisfied with the decision rendered by the Board may have 30 days to appeal.

<b>FOR OFFICE USE ONLY</b>			
Date Received _____			
Category	O _____	P _____	P&O _____
New Application	<input type="checkbox"/>	Renewal	<input type="checkbox"/>
Application fee included	Y <input type="checkbox"/>	N	<input type="checkbox"/>
Approved	<input type="checkbox"/>	Rejected	<input type="checkbox"/>
Date Accredited _____			

# I. IDENTIFICATION

Application Date \_\_\_\_\_

a) Full legal name of Facility \_\_\_\_\_  
\_\_\_\_\_

b) Name of Owner \_\_\_\_\_

c) Name and Title of Manager: \_\_\_\_\_  
Certified: Yes ( ) No: ( )

d) Name of Principal Prosthetist/ Orthotist: \_\_\_\_\_

e) Facility's Address: \_\_\_\_\_

(City) \_\_\_\_\_ (Province) \_\_\_\_\_ (Postal Code) \_\_\_\_\_

(Telephone) \_\_\_\_\_ (Fax) \_\_\_\_\_

Contact E-mail \_\_\_\_\_

f) Type of Facility:

Private ( ) Government ( ) Hospital ( ) University ( )

Other ( ) \_\_\_\_\_  
(Specify)

*(Note: If applicant is in more than one category, mark all applicable categories)*

g) Date Facility Began Practice \_\_\_\_\_

h) If applicable, date of original accreditation \_\_\_\_\_

i) Check here if application is filed due to relocation of your facility ( )

## II. QUALIFICATIONS DATA

a) **Category of Accreditation Applied for:**

Orthotics ( )                      Prosthetics ( )                      Prosthetics & Orthotics ( )

Extension of title in:                      Orthotics ( ) Prosthetics ( )

Renewal in:                      Prosthetics ( )                      Orthotics ( )

Prosthetics and Orthotics ( )

Facilities that are accredited in one discipline but dispense services in the second discipline not having an appropriately certified individual of that second discipline on staff, are liable to investigation by the ethics committee that may lead to having their facility accreditation terminated.

b) **Identification of Associated Certified Practitioners:**

No certified practitioner is now associated on a full time basis ( )

The following full time certified practitioners are employed by this facility on this date:  
(The first name should be that of the principal certified practitioner whose name will appear in the Registry).

\*Name \_\_\_\_\_

C.B.C.# in    P \_\_\_\_\_ O \_\_\_\_\_ Date employed \_\_\_\_\_

Name \_\_\_\_\_

C.B.C.# in    P \_\_\_\_\_ O \_\_\_\_\_ Date employed \_\_\_\_\_

Name \_\_\_\_\_

C.B.C.# in    P \_\_\_\_\_ O \_\_\_\_\_ Date employed \_\_\_\_\_

Name \_\_\_\_\_

C.B.C.# in    P \_\_\_\_\_ O \_\_\_\_\_ Date employed \_\_\_\_\_

c) **Indicate if Applicant Facility meets the following minimum requirements:**

		YES	NO
1.	Separate Office Area		
2.	Separate reception and waiting room		
3.	System of maintaining patient's records		
4.	Patient care area separate from laboratory (shop) area		
5.	Private fitting rooms. How many? _____		
6.	Area permanently equipped with parallel bars, hand railings, mirrors		
7.	Laboratory (shop) area separated and closed off from rest of facility		
8.	Is patient area on ground floor?		
9.	Are elevators and/or ramps provided?		
10.	Are rest rooms provided with access not through laboratory shop? How many? _____		
11.	Facility meets all local health, safety, building, fire regulations		
12.	Does the facility use central fabrication services?		
13.	Does facility have full on-site patient service capability?		
14.	Does the facility maintain a complete file for each patient?		
15.	Does/Has the facility conducted a Patient Satisfaction Survey?		
16.	Does the facility have a refund and warranty policy?		
17.	Does the facility possess appropriate tools in good working order?		

d) **Client Satisfaction Survey**

**Enclosed with this application are twenty (20) CLIENT SATISFACTION SURVEY forms. Please put the name of your facility on the form and mail the form and the envelope addressed to C.B.C.P.O. to your patients. Please retain a list of the patients that the survey was sent to for future reference/follow-up.**

e) **Patient File Audit Summary**

Describe the patient files maintained by your facility or send a sample file, which should contain:

- a) Basic patient information and assessment
- b) Progress notes

The facility is required to audit its files. Please summarize your results to establish a base line.

Summarize the facilities most recent patient file audit results.

	Prosthetic Files			Orthotic Files		
	% Yes	% No	% N/A	% Yes	% No	% N/A
Written Referral or Prescription						
Assessment of Patient prior to Service						
Problem Identification and Interventions						
Outcome of care						
Evidence of Education of Patient & Family						
Instructions for follow up care						
Communication with Referring Party						
Total # of Files Audited						

*Yes - Meets Facilities Standards    No - Does Not Meet Facilities Standards    N/A - Not Applicable*

Note: You may substitute an appropriate format at your discretion.

f) **Patient Satisfaction Survey**

**g) Conduct a patient satisfaction survey and summarize the results as follows:**

<b>Total Number of Prosthetic Patients Surveyed</b>	
<b>Total Number of Orthotic Patients Surveyed</b>	
<b>Total Number of Patients Surveyed</b>	
<b>% Using Orthosis</b>	
<b>% Using Prosthesis</b>	
<b>% of Orthotic Patients satisfied with service</b>	
<b>% of Prosthetic Patients satisfied with service</b>	

**Note: You may substitute an appropriate format at your discretion.**

**g) Warranty and Refund Policy**

**Provide a statement of your facilities warranty and refund policy.**

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**h) ATTACH THE FOLLOWING TO THE APPLICATION**

- 1. A readable outline floor plan with dimensions showing the facility's physical layout and placement of equipment.**
- 2. A video tape OR one set of six or more photographs, (minimum size 4" x 5")(B & W or colour) which show the following views of the facility:  
  
Exterior front view ( ), parking area ( ), reception area ( ), waiting area ( ), fitting room ( ), different views of shop area showing minimum equipment ( ), access to rest room(s) ( ).**
- 3. Submit a recent (within the last 12 months) written report obtained from the appropriate authorities attesting to the fact that the facility complies with all local health, safety, building and fire regulations.**
- 4. Provide evidence that dust-generating equipment is equipped with or linked to an appropriate dust recuperation system.**
- 5. Provide evidence of an adequate fume extracting system.**
- 6. Enclose an accreditation fee of \$250.00 plus applicable taxes.**

### III. REFERENCES

Provide the complete names, addresses and telephone numbers of three references (at least one of whom must be an orthopaedic surgeon or doctor of physical medicine who have used your facility to provide orthotic and/or prosthetic care to their patients in the last twelve months). The other two references may come from physicians or allied health care professionals.

1) **Name:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2) **Name:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3) **Name:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## IV. VALIDATION

The undersigned certifies:

- (1) That he/she is a duly authorized representative of the organization that is filing this application for Facility Accreditation;
- (2) That the applicant facility is engaged as the principal part of its business in providing orthotic and/or prosthetic management to patients who are disabled;
- (3) That said Applicant facility complies with all requirements set out by The Canadian Board for Certification of Prosthetists and Orthotists, governing the class of patient management (orthotics and/or prosthetics) for which application is made to the best of the undersigned's knowledge and belief; and
- (4) That the information provided in this application in support of the Applicant facility's eligibility of accreditation is true and correct to the best of his/her knowledge and belief.

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In witness whereof, the undersigned has hereunto set his/her hand, this \_\_\_\_\_  
day of \_\_\_\_\_, 20 \_\_\_\_.

-  
\_\_\_\_\_  
Signature and title of Authorized Representative

\_\_\_\_\_  
Name of Representative (Printed or Typed)

\_\_\_\_\_  
Witness Signature