ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

Application Form

Practice Eligibility Route for Areas of Focused Competence (PER-AFC)

Advanced Heart Failure and Cardiac Transplantation

Candidates pursuing this route must meet the discipline specific eligibility criteria outlined below prior to applying.

Eligibility Criteria

- Candidates applying to this route should be practicing within the scope of the Advanced Heart Failure and Cardiac Transplantation discipline.
- Candidates must be practicing in the domain for a minimum of 5 years prior to applying.
- Royal College certification in Adult or Pediatric Cardiology, or equivalent, is required.

Goals

An AFC Diplomate is expected to function as a competent specialist in Advanced Heart Failure and Cardiac Transplantation, capable of an enhanced practice in this Area of Focused Competence, within the scope of Cardiology. The PER-AFC applicant must demonstrate a working knowledge of the theoretical basis of the discipline, including its foundations in science and research, as it applies to medical/surgical practice.

The discipline of Advanced Heart Failure and Cardiac Transplantation also includes responsibility for:

- management of patients with heart failure for purposes of risk stratification, prognosis, and suitability for advanced treatment options;
- collaborative management of patients with cardiomyopathy;
- longitudinal management of patients with heart failure, providing ongoing hemodynamic assessment and tailoring of medical and device-based therapy;
- provision of care for cardiac transplant recipients;
- management of patients receiving mechanical circulatory support (MCS);
- collaborative practice within the interprofessional team; and
- advancement of the field of advanced heart failure and cardiac transplantation.

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Please attach the following documents to your application:	
☐	Copy of your CV
☐	Copy of your license to practice
☐	Copy of certification in Cardiology *(if other than RCPSC)*

Please send your completed application forms to:	
Email: diplomas@royalcollege.ca	Fax: (613) 730-3707

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Please note:

- You will receive confirmation of receipt of your application via email.
- The Royal College will remain in contact with you via email. Please ensure we always have your current email address on file.
- You will be contacted directly should we require additional information at any point during the assessment process.

Personal details			
Identification			
RC ID (if applicable)		Date of birth	
Surname			
Given name		Middle name	
Contact information			
☐ Personal address ☐ Business address		Apartment number	
Street number and name		City	
Province		Postal code	
☐ Personal ☐ Business		☐ Personal ☐ Business	
Phone		Email	

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Credit card authorization form *One time use only*		Date	
Applicant information			
Name of applicant			
Amount	$1,950 *The Royal College will charge the credit card in $CAN*	Card type	☐ Visa ☐ Mastercard ☐ American Express
Credit card information			
Card number			
Expiry date			
Cardholder's name			
☐ I agree	By selecting "I agree", the Royal College is authorized to charge the non-refundable assessment fee to the credit card listed above for the amount indicated.		

Royal College use only			
Date		Rev. code	339
ID number		Amount	$1,950

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Declaration		
By clicking "I agree", you are agreeing to the following: • All personal, biographical, and academic information relating to your training and practice is confidential and is provided for the recognized legitimate use by the staff of the Royal College. • The Royal College may receive and exchange any and all information which may be requested relative to your training and practice history, credentialing, examination eligibility, scope, and competencies in practice from your Chief of Staff, Head of Department, or any other supervisor to whom you report; the Medical Regulatory Authority in the location you practice; and any and all institutions where you undertook postgraduate medical education training. • Any misinformation in this application or in any document at any time, provided by you in support of your application, may lead to refusal of your application or withdrawal of eligibility previously granted. • To abide by the decisions of the Royal College of Physicians and Surgeons of Canada		
☐ I agree	Date	
Name		

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Scope of Practice

- Every physician's scope of practice is unique.
- 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.
- A physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills, and judgement, which are developed through training and experiences in that scope of practice.

Name of applicant	

1) How many years have you been practicing in Advanced Heart Failure and Cardiac Transplantation?
2) How many hours per week or month do you spend in Advanced Heart Failure and Cardiac Transplantation activities?

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3) What percentage of your professional time is spent in the practice of Advanced Heart Failure and Cardiac Transplantation?
4) Do you practice in another specialty or subspecialty? If so, please describe your practice.
5) Briefly describe your current practice/involvement in Advanced Heart Failure and Cardiac Transplantation in the past 12 months *(including practice involving heart failure clinic, inpatient heart failure service or other applicable service, VAD/transplant clinics, other specialty clinics as they relate to heart failure, etc.).*

6) Please include your role in the ventricular assist device/mechanical circulatory support program, including breadth of device exposure (temporary and durable).
7) Please include your role in the cardiac transplant program.
8) On average, how many hours per week are you involved in medical professional activities? This should include clinical, teaching, research, and administration.

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9) In the chart below, please indicate in which location you see patients, the number of patients seen, and the number of hours spent in direct patient contact during a *typical work month.*		
Practice setting	# patients seen per week	% hours spent in direct patient contact per week
OFFICE PRACTICE (non-hospital based)		
Private office		
Community Health Centre		
Other (name)		
HOSPITAL (Inpatients)		
Advanced Heart Failure patients		
VAD patients		
Transplant patients		
HOSPITAL (Outpatients)		
Advanced Heart Failure patients		
VAD patients		
Transplant patients		
Other specialty patients *(i.e., cardio-oncology, amyloid, HCM, etc.)*		

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10) Please list a minimum of 10 of the most common conditions/diseases/procedures that you see/perform in your practice.	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

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11) Please provide a summary of how you meet the Competency Training Requirements (CTR) in Advanced Heart Failure and Cardiac Transplantation.

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Please provide the name, email address, and telephone number for the following list of individuals for use by the Royal College to conduct the Multisource Feedback (MSF) process.
By providing the information below, you are authorizing the Royal College to contact these individuals to collect feedback on your practice in Advanced Heart Failure and Cardiac Transplantation, including providing a copy of your scope of practice document, completed as part of this application. *You are also authorizing the individuals below to provide feedback on your practice in Advanced Heart Failure and Cardiac Transplantation.*

Referee identification
Referees must be recent and have had contact with you within the last 24 months. A minimum of 5 MSF questionnaires are required, including at least one (1) from each of the following individuals: • Ventricular-Assist Device (VAD) Coordinator • Transplant Coordinator • Physician Colleague

Ventricular-Assist Device (VAD) Coordinator		
1.	Title and name:	
	Email address:	
	Telephone number:	

Transplant Coordinator		
2.	Title and name:	
	Email address:	
	Telephone number:	

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Physician Colleague		
3.	Title and name:	
	Email address:	
	Telephone number:	
Department Head		
4.	Title and name:	
	Email address:	
	Telephone number:	
Other(s)		
5.	Title and name:	
	Email address:	
	Telephone number:	
6.	Title and name:	
	Email address:	
	Telephone number:	