

EMPLOYMENT AND SUPERVISION PROPOSAL

For Interim Registration

The following template is provided to guide you in establishing an appropriate supervision plan for an interim registrant with the College of Physical Therapists of BC. You may use this template or your own form of supervision plan but it must include all the provisions in this template. Please be advised that your employer(s) will be mailed a copy of your registration approval letter.

Name of Interim Registration Applicant _____

SUPERVISING PHYSICAL THERAPIST(S) *

* Interim registrant can only have a maximum of two supervisors at a time.

Name & Full Registration No.: _____

Name & Full Registration No.: _____

EMPLOYMENT INFORMATION*

* Interim registrant can only have a maximum of two worksites at a time. Please submit a *separate* supervision plan for each workplace.

Name of Workplace _____

Workplace Address _____

Workplace Telephone Number _____

Date of Employment _____ TO _____

Primary Area of Practice (Choose one only):

- | | | |
|---|--|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Health Promotion and Wellness | <input type="checkbox"/> Plastics |
| <input type="checkbox"/> Amputations | <input type="checkbox"/> Mental Health & Psychiatry | <input type="checkbox"/> Research |
| <input type="checkbox"/> Burns & Wounds | <input type="checkbox"/> Mentally Challenged | <input type="checkbox"/> Respiriology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Return to Work Rehab |
| <input type="checkbox"/> Client Service Management | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Oncology | <input type="checkbox"/> Sales |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Orthopaedics | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Early Childhood Intervention | <input type="checkbox"/> Other | <input type="checkbox"/> Teaching – Other |
| <input type="checkbox"/> Ergonomics | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Teaching – PT Related |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Vestibular Rehab |
| <input type="checkbox"/> Gerontology | <input type="checkbox"/> Perineal | |

Employment Category:	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary	<input type="checkbox"/> Casual
Employment Status:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	
Age of Clients:	<input type="checkbox"/> Adults	<input type="checkbox"/> All ages	<input type="checkbox"/> Pediatrics <input type="checkbox"/> Seniors
Level of Clients:	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic	<input type="checkbox"/> Long Term <input type="checkbox"/> Mixed <input type="checkbox"/> Rehab

DUTIES OF SUPERVISOR(S)

1. Before starting employment, I will orient the applicant to the policies and procedures in effect at the clinic/hospital and review the materials in the College's Reference Guide;
2. I will review the applicant's charts _____ (frequency) _____ and will advise him/her regarding proper charting practice and procedure in accordance with the standards of practice of the College of Physical Therapists of BC;
3. I will review the applicant's billings _____ (frequency) _____ and will provide advice and direction to him/her. If necessary, I will make appropriate adjustments to the billings;
 By checking this box and signing with my initial at the end of this sentence, I confirm that this supervisory arrangement takes place in a hospital and therefore this item is not applicable. _____
4. I will be physically present to consult with the applicant _____ (frequency) _____ at the clinic or hospital;
5. When I am not physically present at the clinic or hospital, I will be available for consultation and advice at all times by telephone;
6. In the event that I am away on vacation, because of illness, or for any other reason for a period of greater than three weeks, I will ensure that another full registrant of the College is available in my place to carry out the terms of this plan **and will first obtain approval of the Registration Committee for another full registrant of the College to act as a supervising therapist;**
7. In the event that I have concerns regarding the applicant's competency to practice physical therapy in any respect, I will report my concerns immediately to the Registrar of the College of Physical Therapists.

If applicable:

8. I attest that the applicant is employed by a facility owned by _____ (name of health authority) _____ and, as such, is insured against liability for negligence in an amount of at least three (3) million dollars per occurrence.
9. I will review the applicant's dry needling practices _____ (frequency) _____ and I confirm my competency to practice dry needling by submitting proof of completion of one or more of the following to the Registration Committee:
 - the Level 1 (Parts 1, 2A, and 3A) of Acupuncture Foundation Canada Institute;
 - the University of Alberta, Faculty Extension's Certificate Program in Medical Acupuncture;

- the Intramuscular Stimulation program at the Institute for the Study and Treatment of Pain (ISTOP);
- McMaster University Contemporary Acupuncture for Health Professionals Program;
- Manitoba based Acupuncture for Physiotherapists: The Art and Science;
- The International College of Traditional Chinese Medicine of Vancouver courses 100, 101, 103, 212 AB, 213, 306; or the Certificate for Health Professionals Levels I-IV;
- McMaster University Medical acupuncture Program: An evidence-Based Approach to Traditional Chinese Medicine; or
- a program of academic education or combination of academic education and practical experience that is equivalent to the programs listed above and it has been approved by the Acupuncture Credentialing Sub-Committee on _____ (date) _____.

DUTIES OF APPLICANT FOR INTERIM REGISTRATION

1. I agree to co-operate with the supervising physical therapist and provide him/her with access to all my charts. I will seek the advice of the supervising physical therapist when necessary and will follow his/her direction;
2. I agree to provide my supervising physical therapist with access to all billings that I render and I agree to review the billing for the services that I provide.
 By checking this box and signing with my initial at the end of this sentence, I confirm that this supervisory arrangement takes place in a hospital and therefore this item is not applicable. _____
3. I agree to complete the Physiotherapy Competency Examination and I have both:
 registered for passed the QE on _____ (DATE of examination) _____
 registered for the PNE: _____ (DATE of examination) _____
4. I understand that if the College is advised that a relevant criminal record exists with respect to me, my interim registration may be further restricted or revoked;
5. I agree that I will not work for any other employer or at any other location. Further, if I make any changes to my employment arrangement (e.g. change employers or location of employment), I will submit a written request, a letter of reference from my previous employer, another supervision plan, and an administrative fee (only applicable for second and subsequent requests) for approval to the Registration Committee.
6. I understand that if I fail Part One (Qualifying) of the Physiotherapy Competency Examination, I must inform the College and my interim registration shall be revoked by the Registration Committee. The College shall inform my employer in writing that my interim registration has been revoked.
7. I understand that if I fail Part Two (Clinical) of the Physiotherapy Competency Examination, I must inform the College and my interim registration may be further restricted or revoked, at the discretion of the Registration Committee. The College shall inform my employer in writing of any changes of my registration status and condition.

If applicable:

8. I confirm that my educational credentials for dry needling have been approved by the Acupuncture Credentialing Sub-Committee on _____ (date) _____. I will ensure that my

supervisor(s) has the approved qualification to practice dry needling and he or she is willing to supervise my dry needling practice.

SHARED DUTIES OF APPLICANT AND SUPERVISOR(S)

We understand that if the terms of section 32 of the College's Bylaws or Policy 4.11 are not met by either the supervising therapist or the interim registrant, interim registration may not be granted or, if granted, may be further restricted, not extended or revoked. We understand that interim registration may not be granted or may be revoked if the supervising therapist is under investigation or disciplinary action by the College. We further understand that a breach of section 32 of the College's Bylaws, Policy 4.11 or the general standards of the profession may result in an investigation or discipline under the *Health Professions Act*.

We understand that a potential conflict of interest arises when the supervisor(s) is related to the applicant for interim registrant or is a closer personal friend with the applicant. We understand that we must declare any potential conflict of interest to the College and as a result, alternative supervisory arrangement may be required or interim registration may not be granted at the discretion of the Registration Committee.

Submitted by:

Supervising Therapist

Supervising Therapist

Interim Registrant

Date

Approved by:

for Registration Committee