Saskatchewan Workers' Compensation Board

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Toll free: 1.800.667.7590
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Toll free fax: 1.888.844.7773

Attn: WCB health-care services quality assurance — administrative assistant

Accreditation request – treatment team member

To be completed by clinical co-ordinator

Name of care provider applicant: _____

Discipline: _____

Name of team member the applicant is replacing: _____

Name of clinical co-ordinator applicant is replacing: _____

Name of team: _____

Applicant will be performing:	FAE	❑ Yes	❑ No
	FCE	❑ Yes	❑ No
	Vestibular tx	❑ Yes	❑ No
	Manipulation tx	❑ Yes	❑ No

The WCB can confirm information by contacting:

Name: _____ Phone: _____

With this application, include the documents that demonstrate how the applicant meets the accreditation requirements. Submit these documents with each application, even if you have submitted them with a previous accreditation request.

Team chair:

Name: _____

Address: _____

City/town: _____

Postal code: _____

Phone: _____

Fax: _____

I confirm that this team complement continues to meet the WCB's requirements for members with treatment team experience.

_____ _____

Signature of team chair Date

CLEAR FORM