

Mission Statement

The Alberta College of Medical Diagnostic and Therapeutic Technologists exists so that the public is assured of receiving safe, competent and ethical diagnostic and therapeutic care by regulated and continually advancing professions.

Alberta Diagnostic Medical Sonographers Roster Application

If you are a professional practicing diagnostic medical sonography in Alberta, you may volunteer to apply for the Alberta **Diagnostic Medical Sonographer (DMS)** Roster of the Alberta College of Medical Diagnostic and Therapeutic Technologists (ACMDTT or the College). The practice of DMS involves not only the clinical and technical aspects of the profession; it also includes, but is not limited to, functions of supervision, education, management, research and administration.

Here are the key things you should know:

- ☑ There is no fee at this time. Payment will be required once registration opens. (Your payment will be the full application fee of \$100 and the registration fee.)
- ☑ When Alberta Health has completed its ongoing process of amending the *Medical Diagnostic and Therapeutic Technologists Professions Regulation*, it will become unlawful to practice without prior registration as a member regulated through the ACMDTT.

All professionals on the Roster will, if approved by ACMDTT, be grand-parented into regulated status through the register of the ACMDTT.

All professionals who have not participated in the Alberta DMS Roster processes will have to complete their entire application process within the grand-parenting window.

- ☑ All professionals on the Roster will receive the following benefit when it is time to be grand-parented into the ACMDTT's regulated register:
 - Expedited pathway to registration as the administrative process will already be complete. This will likely consist of:
 - Completion of an online Regulation Education Module (REM)
 - Completion of a declaration confirming an understanding of regulatory obligations
 - Payment of application fee and registration fee
 - Declaration that all information submitted under the Alberta DMS Roster is still true and valid
- ☑ The College will apply the robustness of its current registration process in order to process the application for a sonographer. This may include approval by the Registrar or the Registration Committee of the ACMDTT.
- ☑ In the future, only sonographers on the ACMDTT's regulated register will be allowed to practice in Alberta and use the protected title of "diagnostic medical sonographer" or "DMS".

This package includes an application guide and form. Please review the guide prior to completing the form.

For questions specific to your situation, please contact the College at: 780.487.6130, toll-free 1.800.282.2165 or dms@acmdtt.com.

Guide: Alberta Diagnostic Medical Sonographers Roster Application Process

The ACMDTT is pleased to provide this guide to assist your application to be on the Alberta DMS Roster. Information you provide to the College is protected as per the College's [Privacy Policy](#), available on the College website at www.acmdtt.com, under the tab titled 'About us'.

Section 1: Applicant Information

Practice name

If the name you use in your practice is different from your legal name, please provide it here. In the future, when your information is rolled into the regulated register of medical diagnostic and therapeutic technologists, your practice name will appear on the ACMDTT's Public Register.

The Public Register is a list of registered members available through a link in the footer of the [College website](#). It provides the public with the member's professional title with specialty, registration status and conditions on practice (if any) and acts as proof of registration with the ACMDTT.

Please note that the online Public Register will not provide information about professionals on the Alberta DMS Roster. Only once sonographers are registered and regulated will this information become public.

Previous last name

Enter your previous last name(s) if you have ever changed your name since completing your education to practice the profession. You must provide a photocopy of your marriage certificate, divorce decree, or legal name change document.

Email address

The College requires your active email address to communicate with you. Important and confidential information may be sent by email, so please ensure the email address you provide is secure and checked frequently.

By choosing "Yes" to email consent, you are providing consent to receive electronic messages regarding member services such as branch activities for professional development, the annual conference, the College newsletter and awards. Electronic messages to communicate regulatory related matters that fall under *the Health Professions Act* (HPA) are sent to all members electronically regardless of their consent decision regarding membership services.

Section 2: Subspecialty(ies)

Your subspecialty(ies) correlate(s) to your area of certification.

If you have never been certified to practice your specialty or if your practice does not fall in the specialties identified in this form, please choose 'other' and provide a broad description of your specialty. College staff will work with you to identify the information pertinent to providing regulatory oversight to your practice. Your specialty may be unique to you or a select few sonographers in Alberta.

Section 3: Employment Information

Provide your employment information as indicated. Record your supervisor's contact information as they may be contacted with respect to the information you have provided. If you have more than two employers, add a separate page with this information.

Section 4: Educational/Training Information

Provide information about your initial sonography educational program.

Submit a copy of your diploma or degree, or a letter/notification from the educational institution that issued the diploma or degree evidencing your education.

Section 5: Certification Information of Subspecialty

If you have indicated that you are certified in your subspecialty in section 2 of this form, provide information about your certification. Submit a copy of your certification, or a letter/notification from the certifying body evidencing your certification.

If you have not received certification in your subspecialty, please leave this section blank.

Section 6: Professional Conduct

If you answer YES to question 6.2 and/or 6.3, please provide further information. If required, the College will contact you to request any additional information.

Section 7: Additional Restricted Activities

Alberta Health defines restricted activities as high-risk activities that are carried out in relation to, or as part of, performing a health service. Please indicate if you provide one or more of the listed restricted activities.

Professionals that practice these additional restricted activities will be required to verify maintenance of competence to perform these activities through a supervisor validated process when they are grand-parented into the ACMDTT's regulated register.

Section 8: Declaration

You must check off, sign and date the declaration section of the form in order for your application to be complete. Your signature means that you have read and agree to all statements in this section.

If you provide incorrect or false information to ACMDTT, you could be denied registration on the ACMDTT's regulated register or any registration issued to you could be revoked.

Section 9: Practice History

Professionals may practice many subspecialties (as indicated in section 2 of this form). If you have more than one subspecialty, the primary subspecialty is the subspecialty that you practiced the most in the previous five years. Your other subspecialties are considered your secondary subspecialties. This means that you can have only one primary subspecialty and more than one secondary subspecialty.

- The College requires evidence of a minimum of 800 hours of practice in your primary subspecialty within the previous five years.
- If applicable to your situation, the College requires evidence of a minimum of 160 hours of practice in each secondary subspecialty.
- Practice hours include practice in a clinical setting, supervision, education, management, research and administration.
- Practice hours do not include vacation, sick time, leave of absence or any other paid/unpaid non-practice hours.
- This information must be verified by your employer via your supervisor or human resources personnel. Provide a separate completed section 9 for each employer and/or specialty.
- You can send section 9 separately from this application form. Your record at the College will be augmented with each piece of information as it is received by College staff.

General Information

Incomplete applications

Applicants who submit incomplete information will be notified by email and provided a list of missing documentation. You are welcome to submit your documents as they become available; however, your application cannot be processed until all the required information is received at the College.

Processing Time

The College will attempt to process your application within 30 business days of receiving the completed application and all required documentation. Once your application has been processed, the College will provide confirmation through email that the process has been successfully completed.

If there are higher levels of information required to ensure that you meet all of the requirements, the College will communicate with you to request more information, and keep you apprised of next steps.

Checklist of documents to be included with your application:

- Completed application
- If applicable, copy of name change document
- Copy of education
- Copy of certification
- Employer authentication of practice (section 9)

If you plan to email your information, please provide each document as a distinct and separate image.

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Application: Alberta Diagnostic Medical Sonographers Roster

Section 1: Applicant Information			
Surname	Given Name(s):	Practice Name:	Previous Last Name: (if applicable)
Home Address	City/Province/Country		Postal Code
Date of Birth DD MM YYYY	Telephone	Email Address	<input type="checkbox"/> Yes , please send me information about membership services.
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X			
Section 2: Subspecialty (Check all that apply)			
<input type="checkbox"/> General <input type="checkbox"/> Cardiac <input type="checkbox"/> Vascular <input type="checkbox"/> MSK <input type="checkbox"/> Other _____			
Section 3: Employment Information (You must have place of employment in Alberta to be included in the Roster)			
3.1: Primary Place of Practice in Alberta		3.2: Secondary Place of Practice in Alberta	
Employer's name:		Employer's name:	
Employer's address:		Employer's address:	
Work phone number:		Work phone number:	
Supervisor's name:		Supervisor's name:	
Supervisor's phone number:		Supervisor's phone number:	
Supervisor's email:		Supervisor's email:	
Start Date in Alberta: DD MM YYYY		Start Date in Alberta: DD MM YYYY	
Section 4: Educational/Training Information		Secondary Education/Training Information (if applicable)	
4.1: Educational Program Name		4.2: Educational Program Name	
<input type="checkbox"/> Diploma <input type="checkbox"/> Degree <input type="checkbox"/> Hospital/employer trained <input type="checkbox"/> Other: _____		<input type="checkbox"/> Diploma <input type="checkbox"/> Degree <input type="checkbox"/> Hospital/employer trained <input type="checkbox"/> Other: _____	
Program Start Date: DD MM YYYY	Program Completion Date: DD MM YYYY	Program Start Date: DD MM YYYY	Program Completion Date: DD MM YYYY
Name, Address and Postal Code of Institution/Hospital		Name, Address and Postal Code of Institution/Hospital	
Language of Instruction:	Certificate Date: DD MM YYYY	Language of Instruction:	Certification Date: DD MM YYYY
<input type="checkbox"/> I have provided evidence of this education/training		<input type="checkbox"/> I have provided evidence of this education/training	

Section 5: Certification (if applicable)**5.1: Name of certifying body****5.2: Name of certifying body**

Certification Date:

Certification name:

Certification date:

Certification name:

DD MM YYYY

DD MM YYYY

 I have provided evidence of this certification I have provided evidence of this certification**Section 6: Professional Conduct** (Please circle "Yes" or "No")

6.1 Are you currently a member of another provincial body or professional college or association?
If yes, please list them here:

Yes No

6.2 Have you ever been disciplined or are you currently being investigated by a professional association or regulatory body? (If yes, please provide details on a separate page.)

Yes No

6.3 Do you have a criminal record? If yes, please attach details on a separate page. (You are not required to obtain a criminal record check without a specific request from ACMDTT.)

Yes No

6.4 Do you give permission to the College to contact any authority or association in any jurisdiction to verify the above statements? (The College must be able to verify your information.)

Yes No

Section 7: Additional Restricted Activities

Please indicate if you practice any of the following:

Contrast Media Medication Administration Venipuncture

Section 8: Declaration (must check all boxes)

- I verify that all statements contained in this application are accurate. I understand that a false or misleading statement, an omission or misrepresentation may be cause for cancellation of my practice permit and registration.
- I understand that the collection, use and disclosure of my personal information will be handled in accordance with the College's Privacy Policy.
- I will advise the College immediately in writing:
- (i) Should I be convicted of any offence in Alberta or in any other jurisdiction
- (ii) Should a finding of or proceeding for professional misconduct, incompetence or incapacity in Alberta or in any other jurisdiction be made or commenced against me in relation to the profession or any other health profession
- I understand that I may be required to submit further information to determine eligibility for registration on the ACMDTT's regulated register of medical diagnostic and therapeutic technologists, and the College will contact me if additional documentation is necessary.

Applicant's Signature _____ **Date (dd/mm/yyyy)** _____

The College reserves the right to request character references and to contact employers.

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Please note: Section 9 needs to be verified by your employer or HR department.

Section 9: Practice History

Provide a completed section 9 for each employer separately. Your record at the College will be augmented with each piece of information as it is received by the College.

9.1: Subspecialty

General Cardiac Vascular MSK Other

Surname:

Given Name(s):

9.2: Most recent practice history accumulating a minimum of 800 hours of work

It is not necessary to list beyond the minimum 800 hours worked. You must break out each specific year.

Year (January – December)	Facility/Organization	Include combined number of hours worked in any subspecialty (General, Cardiac, Vascular, MSK)
2020		
2019		
2018		
2017		
2016		

If the applicant has practiced full time, part time or casual in the subspecialty, please enter the number of hours practiced per year. If the applicant did not practice in the specialty that year, enter '0'.

Note: Practice hours *do not* include vacation, sick time, leave of absence or any other paid/unpaid non-practice hours.
Practice hours *do* include supervision, management, education and quality controls as well as clinical and technical work.

9.3 Employer/Supervisor's Information

Facility/Organization

Employer/Supervisor's Name

Employer/Supervisor's Title

Telephone Number

Email

Employer/Supervisor's Signature

Date (dd/mm/yyyy)

9.4: Supervisor's Declaration

Declaration

I confirm that the information contained in this form is true to the best of my knowledge.

Supervisor's Signature _____ **Date (dd/mm/yyyy)** _____