



# FORM 1: PARTICIPANT APPLICATION FORM

1) Personal Information	
<b>Last Name</b>	
<b>First Name(s)</b>	
<b>Preferred first name</b> <i>(if different than above)</i>	
<b>Credentials</b>	
<b>Continuing Medical Education Credit</b>	<b>Mainpro+</b> - College of Family Physicians Canada (CFPC) <b>Maintenance of Certification (MOC)</b> - Royal College of Physicians and Surgeons of Canada
<b>How did you hear about the Clinical Quality Improvement Program (CQIP)?</b>	From a CQIP graduate or current CQIP participant From a colleague ( <u>not</u> a past CQIP participant) From the Health Quality Council website <a href="http://www.saskhealthquality.ca">www.saskhealthquality.ca</a> Other - please describe:

2) Contact Information	
<b>Employer/Organization</b> <i>(If more than one, list primary employer)</i>	
<b>Title</b>	

<b>Work Address</b>	<i>Site or building (if applicable)</i>	
	<i>Street</i>	
	<i>City, province</i>	
	<i>Postal code</i>	
<b>Phone</b>	<i>Work</i>	
	<i>Cell</i>	
<b>*Email</b>  <i>(Indicate your preferred email address as most communication will be sent to you via email.)</i>		
<b>Preferred address for correspondence, if different than above (e.g. reimbursement cheques)</b>	<i>Site or building (if applicable)</i>	
	<i>Street</i>	
	<i>City, province</i>	
	<i>Postal code</i>	

### 3) Personal: Background Experience & Reasons for Applying

Provide a brief summary of your educational background.

Describe any previous quality improvement training you have had.

Why are you interested in participating in the Clinical Quality Improvement Program?

Describe how you intend to apply the learnings and experience you gain from participating in the Clinical Quality Improvement Program.

**4) Organizational: Current Role(s) and Context**

**What are your current responsibilities or formal role(s) within the health system?**

**What is the context for your clinical work (e.g., hospital, long-term care, primary care, etc.)?**

**Describe the improvement work you are currently involved in (if any), such as committees, teams and projects.**

**How would formal training in clinical quality improvement benefit your work?**

## 5) Proposed Clinical Problem

Respond to the questions that follow to describe the clinical problem you are proposing to address through your participation in the Clinical Quality Improvement Program.

**What is the specific problem you are trying to solve?** Describe how you know that this is a problem.

**In addressing this problem, who do you plan to engage and why?** *(Please include Patient Family Partner involvement, if any)*

**What would success look like in addressing this problem?**

For example: How would addressing this problem benefit patients and families, providers, and the overall system?

**How does addressing this problem connect to the goals, strategies and key actions outlined in the current provincial [health system plan](#)?**

**Applicant Agreements**

**Please check the following boxes to acknowledge your agreement to the following statements.**

I have read the **CQIP Application Guide**.

I am aware of the time commitments (Section 3.0) involved in participating in the Clinical Quality Improvement Program.

I am aware that attendance is mandatory at the in-person Collaborative Learning Labs. If accepted, I agree to attend and participate fully in all five Collaborative Learning Labs.

I understand that the online modules must be completed prior to the in-person Collaborative Learning Lab and that material covered in the online modules will not be re-delivered at the Collaborative Learning Labs.

I understand that if I miss any mandatory component of the program, that I may be asked to reimburse the program for related collaborative learning lab costs and may also be denied reimbursement for related program activities.

I have received sign-off from my supervisor to apply to the program, and if accepted, to attend the in-person Collaborative Learning Labs and make necessary adjustments to my work schedule *(if applicable)*.

I agree that the information submitted on the application form will be used to develop the participant profiles. These profiles will be shared with other participants as a way of building our learning community.

I agree that, if accepted into the program, my project and images of myself will be used in promotional materials on the CQIP web page, CQIP videos, and social media posts.

Signature:

Date:

## Privacy Statement

The personal information requested on this application form is collected under the authority of Section 24 of the Province of Saskatchewan's Local Authority Freedom of Information and Protection of Privacy Act for the purpose of registering and communicating with enrollees in the Clinical Quality Improvement Program. Questions concerning the collection, use, or disposal of this information should be directed to HQC's Privacy Officer: (306) 668-8810 or by email: [privacy@hqc.sk.ca](mailto:privacy@hqc.sk.ca).