

# Specialist Emergency Coverage Program Physician Application Form

Medical Services  
3475 Albert Street  
Regina, SK S4S 6X6  
Phone: 306-787-3437  
Fax: 306-787-3761

Revised January 2021

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## **Application Process**

Physicians that are providing emergency call coverage and wish to be compensated according to the SECP Program Policies, must submit an application to the SECP Committee. Physicians who are currently approved to receive funding from the SECP and are requesting a change in the level of coverage (i.e. Tier I or Tier II) must also apply to the SECP Committee.

The Saskatchewan Health Authority must also submit an application form outlining whether or not it supports the physician application.

All applications must include:

- a) a completed SECP Physician Application Form; and,
- b) a completed SECP Authority Application Form.

Formal applications are not required for:

1. Tier I rotations that are on exceptional status and intend to return to 24/7 coverage following the exceptional circumstance period; or
2. Tier I rotations that meet all of the following:
  - have voluntarily chosen to provide Tier II coverage due to physician resources;
  - have been successful in recruiting physicians and are now able to provide Tier I coverage;
  - have not exceeded 24 months at Tier II; and
  - want to return to Tier I payment.

Even though a formal application is not required in the above two circumstances, notify MSB so that payments can be adjusted.

## **Review and Implementation Process**

Applications will be considered twice yearly with deadlines of January 31 and August 31.

The SECP Committee will review applications following each application date. For changes to existing rotations, decisions will be implemented upon the date that the change in coverage occurred and as agreed upon by the SECP Committee. For new rotation requests, decisions will be implemented from the date that the rotation can confirm that coverage was provided and agreed upon by the SECP Committee. Committee decisions will not be implemented retroactive further than the previous two fiscal quarters.

Direct applications to:

SECP Committee  
c/o Kinda Kealy  
Medical Services Branch, Saskatchewan Ministry of Health  
3475 Albert Street Regina, SK S4S 6X6  
Phone: 306-787-3437 Fax: 306-787-3761 E-mail: [kinda.kealy@health.gov.sk.ca](mailto:kinda.kealy@health.gov.sk.ca)

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<b>Name of Rotation and Location</b>		
<b>Names of Current Participating Physicians</b>		
<b>Type of Request (identify one)</b>	<input type="checkbox"/> new rotation	<input type="checkbox"/> change in tier
<b>Type of Rotation requested (identify one)</b>	<input type="checkbox"/> Tier I	<input type="checkbox"/> Tier II
<b>What hospital setting is the rotation's services provided in?</b>	<input type="checkbox"/> Tertiary	<input type="checkbox"/> Regional
	<input type="checkbox"/> District	<input type="checkbox"/> Community
<b>What geographic area does the rotation provide coverage for?</b>	<input type="checkbox"/> Local Area only	<input type="checkbox"/> Province
	<input type="checkbox"/> Southern Saskatchewan	<input type="checkbox"/> Northern Saskatchewan
<b>What type of call coverage has been provided by the rotation in the last six months?</b>	<input type="checkbox"/> continuous (i.e. 24/7/365)	<input type="checkbox"/> non-continuous
<b>If this is a request for a Tier I rotation, when do you plan to provide continuous coverage, or from what date has continuous coverage been provided?</b>		
<b>Are the physicians on this rotation the first line of call for emergencies?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If No, please explain the process.</b>		
<b>If Yes, how often are you called as the first line of call?</b>		

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<p><b>In the last six months how often were you called to provide specialty care for emergency medical needs of <u>new</u> or <u>unassigned</u> patients?</b></p>	
<p><b>What other specialty or clinical practice is currently available to assist this rotation with their call responsibilities?</b></p>	
<p><b>Describe how care was provided in the past for <u>new</u> or <u>unassigned</u> patients requiring emergency services for your specialty/sub-specialty.</b></p>	
<p><b>What is the back-up plan for emergency patients when call coverage is not provided locally? (Have alternate arrangements been established with a neighbouring call group or physician? If, so what is the plan?)</b></p>	

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	Emergent	Urgent	Non-Urgent
What percentage of on-call cases are within each of these categories (must add to 100%) -- please see below for definitions	_____ %	_____ %	_____ %
How often is it necessary for the on-call physician to physically attend the call in-person	<input type="checkbox"/> very frequently > 85% of all calls <input type="checkbox"/> Frequently 60-84% of all calls <input type="checkbox"/> sometimes < 60% <input type="checkbox"/> never 0%	<input type="checkbox"/> very frequently > 85% of all calls <input type="checkbox"/> Frequently 60-84% of all calls <input type="checkbox"/> sometimes < 60% <input type="checkbox"/> never 0%	<input type="checkbox"/> very frequently > 85% of all calls <input type="checkbox"/> Frequently 60-84% of all calls <input type="checkbox"/> sometimes < 60% <input type="checkbox"/> never 0%
What is the required specialist response time? (choose one under each category)	<input type="checkbox"/> < 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> < 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> < 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> 30-60 minutes

**emergent:** requires emergent care and includes conditions that are a potential threat to life or limb function, requiring rapid medical intervention or delegated acts  
**urgent:** requires urgent care and includes conditions that could potentially progress to a serious problem requiring emergency intervention, such as moderate trauma  
**non-urgent:** conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Position/Title

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Email address