



As detailed in the Policies and Guidelines of the Medical Services Commissions Advisory Committee on Diagnostic Facilities, facility owners must submit capacity-related data and other information to ensure that the Advisory Committee on Diagnostic Facilities (the Committee) receives the data needed to monitor the capability, capacity and performance of diagnostic facilities and services.

Building on Policy 3.1, Transfer of Ownership and Policy 3.5, Ceasing Operations, Policy 5.1, Operational Changes Requiring Notification lists and describes the circumstances when facility owners must provide written notice concerning operational changes that may impact the capability, capacity and performance of a diagnostic facility and/or services.

Using the Operational Changes Notification Form below, facility owners are to notify the Committee, through Diagnostic Facilities Administration, at least 60 days before a change to any of the following:

- A. Facility hours of operation: if different than what was listed on original application or previous notification.
- B. Equipment: changes in major equipment that is expected to result in an increase/decrease of less than 20% of current billing volume; this includes the exchange of old equipment for new equipment
- C. Change in signing authority (i.e. Health Authority CEO or designate).
- D. Ownership: shareholder change of less than 10% financial interest.
- E. Withdrawal: voluntary or other removal of approved outpatient diagnostic service(s) (category/fee items).
- F. Facility Payment Number: any new/additional Payment Number, or a cancellation of an existing Payment Number.
- G. Change of Facility Name or Address: used when Canada Post changes street name, number and/or postal code, or for a change to facility name.
- H. Cease of Facility Operations on a permanent or temporary basis.

Note: For a change in facility Medical Director, please complete this form:

<https://www2.gov.bc.ca/assets/gov/health/forms/1927fil.pdf>

How to Complete and Submit an Operational Changes Notification Form

Facility representatives should complete the applicable section(s) of this Operational Changes Notification Form in as much detail as possible. Additional pages may be added and uploaded with the Operational Changes Notification Form where needed to provide complete information. Please limit change notifications to one Certificate of Approval per form submission.

When complete and authorized, the Operational Changes Notification Form should be submitted through the Committee's secure upload tool located at: <https://www2.gov.bc.ca/submitacdf>

For more information on diagnostic facilities application, assessment and notification processes and the policies that govern the Committee, it is recommended that facility representatives review the Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities, at: <http://www.gov.bc.ca/diagnosticfacilitiespolicies>.



OPERATIONAL CHANGES NOTIFICATION

Include this page with all notifications

Notification Date (YYYY / MM / DD)	Ownership Type <input type="radio"/> Public <input type="radio"/> Private	Owner Name
Facility Name		
Facility Street Address		
Facility Number	Facility Payment Number	
Type of Diagnostic Service Please limit change notifications to one Certificate of Approval per form submission. <ul style="list-style-type: none"> <input type="radio"/> Electromyography (EMG) <input type="radio"/> Electroencephalography (EEG) <input type="radio"/> Nuclear Medicine <input type="radio"/> Radiology <input type="radio"/> Polysomnography <input type="radio"/> Pulmonary Function <input type="radio"/> Ultrasound 		
Type of Notification <ul style="list-style-type: none"> <input type="checkbox"/> A: Facility Hours of Operation (page 2) <input type="checkbox"/> B: Equipment (page 3) <input type="checkbox"/> C: Signing Authority (page 4) <input type="checkbox"/> D: Ownership (page 5-6) <input type="checkbox"/> E: Withdrawal (page 7) <input type="checkbox"/> F: Facility Payment Number (page 8) <input type="checkbox"/> G: Facility Name / Street Address (page 9) <input type="checkbox"/> H: Cease of Facility Operations (page 10) 		

Submitted By

Name	Title
Email Address	Phone Number
Signature	

A: FACILITY HOURS OF OPERATION

Facility Name	Facility Number	Name of Person Submitting Notification
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Complete this section if the hours of operation at a diagnostic facility will change but the change is not expected to decrease/increase the volume of diagnostic testing by 20% or more.

Note: If changing the hours of operation will decrease/increase total test volume by 20% or more over 12-months, or 30% or more over 36-months, an application to amend the facility's approval to bill the Medical Services Plan is required. See Significant Change to Capability or Capacity application forms linked below.

Publicly-owned facility: <https://www2.gov.bc.ca/assets/gov/health/forms/1928bsave.pdf>

Privately-owned facility: <https://www2.gov.bc.ca/assets/gov/health/forms/1929bsave.pdf>

Effective Date of Change (YYYY / MM / DD)							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Current Hours of Operation							
New Hours of Operation							

B: CHANGE OF EQUIPMENT

Facility Name	Facility Number	Name of Person Submitting Notification
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Complete this section if the major equipment used at the diagnostic facility will change but the change is not expected to decrease/increase the volume of diagnostic testing by 20% or more.

Note: If an equipment change is expected to decrease/increase the volume of diagnostic testing by 20% or more over 12-months, or 30% or more over 36-months, an application to amend the facility's approval to bill the Medical Services Plan is required. See Significant Change to Capability or Capacity application forms linked below.

Publicly-owned facility: <https://www2.gov.bc.ca/assets/gov/health/forms/1928bsave.pdf>

Privately-owned facility: <https://www2.gov.bc.ca/assets/gov/health/forms/1929bsave.pdf>

Effective Date of Change (YYYY / MM / DD)

Current Equipment

Name / Brand of Equipment	Year / Make / Model	Daily Exam / Test Limit	Additional Details (as relevant)

New Equipment

Name / Brand of Equipment	Year / Make / Model	Daily Exam / Test Limit	Additional Details (as relevant)

C: CHANGE OF SIGNING AUTHORITY

Facility Name	Facility Number	Name of Person Submitting Notification
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Complete this section if there will be a change in the signing authority (i.e. change of those designated to sign on behalf of a health authority CEO).

Note: For a change in facility Medical Director, please complete this form:
<https://www2.gov.bc.ca/assets/gov/health/forms/1927fil.pdf>

Effective Date of Change (YYYY / MM / DD)

Previous Signing Authority (Supervisory Personnel)

Name	Title	Email Address	Phone Number
Name	Title	Email Address	Phone Number
Name	Title	Email Address	Phone Number

New Signing Authority (Supervisory Personnel)

Name	Title	Email Address	Phone Number
Name	Title	Email Address	Phone Number
Name	Title	Email Address	Phone Number

Conflict of Interest

Appendix A (Conflict of Interest Declaration) and Appendix B (Conflict of Interest Disclosure) must be completed and submitted with the application in order for this application to be considered. For the relevant policies, see Policy 2.4.4 of the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities* and the *Diagnostic Facility Conflict of Interest Policy* at <http://www.gov.bc.ca/diagnosticfacilitiespolicies>

Are Appendix A and Appendix B included with this application? Yes No

D1: CHANGE OF OWNERSHIP (SHAREHOLDERS)

Facility Name	Facility Number	Name of Person Submitting Notification
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Complete this section if the financial interest (ownership) of an approved facility will change and that change reflects 10 % or less of total facility ownership. Include all partners to ensure 100% of ownership is reflected. If required, please include an appendix to this form outlining all shareholder details/information.

Note: If the change of financial interest in an approved facility is greater than 10 %, an application to amend facility's approval to bill the Medical Services Plan is required. In this case please contact Diagnostic Facilities Administration at: DFAdmin@gov.bc.ca to request a Diagnostic Facility Transfer of Material Financial Interest Application form.

Current Ownership Information

Ownership <input type="radio"/> Sole Ownership <input type="radio"/> Partnership or Association <input type="radio"/> Corporation <input type="radio"/> Other (specify): <i>Please fill out the applicable section below relating to which button was checked.</i>
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Sole Ownership

Owner Name

Owner Business Address

Partnership or Association (please list each partner, associate or financial beneficiary; append listing if required)		
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Name of Partner/Associate/Financial Beneficiary	Business Address	Percentage Owned

Corporation (please provide the full name, business address and corporate title for all Officers and Directors; append listings if required)		
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Corporation Name	Corporation No.	Date of Incorporation
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Name of Officer/Director	Business Address	Title

Name of Shareholder(s)	Address	Percentage Interest

D2: CHANGE OF OWNERSHIP (SHAREHOLDERS)

Future Ownership Information

Ownership <input type="radio"/> Sole Ownership <input type="radio"/> Partnership or Association <input type="radio"/> Corporation <input type="radio"/> Other (specify): <i>Please fill out the applicable section below relating to which button was checked.</i>	Effective Date of Change (YYYY / MM / DD)
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Sole Ownership

Owner Name

Owner Business Address

Partnership or Association (please list each partner, associate or financial beneficiary; append listing if required)

Name of Partner/Associate/Financial Beneficiary	Business Address	Percentage Owned

Corporation (please provide the full name, business address and corporate title for all Officers and Directors; append listings if required)

Corporation Name	Corporation No.	Date of Incorporation
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Name of Officer/Director	Business Address	Title

Name of Shareholder(s)	Address	Percentage Interest

Foreign Interest

Is the proposed diagnostic facility that is the subject of this application owned, in whole or in part, for a foreign interest? *For the purpose of this application, foreign interest means: any form of business enterprise or legal entity organized, chartered, or incorporated under the laws of a country other than Canada, or a person who is not a citizen or national of Canada.*

Yes No Note: Applications involving a foreign interest are subject to ACDF policy 2.4.5 *Assessment Criteria: Compliance with Canadian and BC Law*, and may require additional actions from applicant. For further information, see the ACDF policy document at: <http://www.gov.bc.ca/diagnosticfacilitiespolicies> or contact Diagnostic Facilities Administration through DFAdmin@gov.bc.ca

Conflict of Interest

Appendix A (Conflict of Interest Declaration) and Appendix B (Conflict of Interest Disclosure) must be completed and submitted with the application in order for this application to be considered. For the relevant policies, see Policy 2.4.4 of the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities* and the *Diagnostic Facility Conflict of Interest Policy* at <http://www.gov.bc.ca/diagnosticfacilitiespolicies>

Are Appendix A and Appendix B included with this application? Yes No

Facility Name	Facility Number	Name of Person Submitting Notification
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Withdrawal of an Outpatient Diagnostic Facility's Approved Service(s) Categories and/or Fee Items

Please complete this section if accreditation by the College of Physicians and Surgeons of British Columbia's Diagnostic Accreditation Program is no longer valid for an approved outpatient diagnostic fee item(s), or the facility will voluntarily no longer provide one or more specific outpatient diagnostic facilities categories and/or fee items.

Review Medical Services Plan diagnostic services Category and Fee Item Listings: <https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/diagnostic-lab-services/diagnostic-services/categories-and-fee-items>

Note: If the Withdrawal of Approved Outpatient Diagnostic Facility Service(s) results in a change in facility hours, then Section A (Hours of Operation) is to be completed.

Effective Date of Change (YYYY / MM / DD)

Approved outpatient diagnostic facility services/categories and/or fee items to be withdrawn (please list all that apply)

Category(ies) of Tests	Fee Item(s) (if applicable)

F: CHANGE OF FACILITY PAYMENT NUMBER

Facility Name	Name of Person Submitting Notification
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Complete this section to add or cancel a Payment Number associated with a Facility Number. If additional space is required for facility information and/or Payment Numbers, please include an appendix.

Note: Payment Numbers are issued by Health Insurance BC (HIBC). Contact HIBC at:
<http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-insurance-bc>

Effective Date of Change (YYYY / MM / DD)

Current Payment Number

Facility Name	Facility Number	
Mailing Address		
Current Payee Number	Current Payee Name	End Date (YYYY / MM / DD)

New Payment Number

New Payee Number	New Payee Name	Start Date (YYYY / MM / DD)
New Payee Number	New Payee Name	Start Date (YYYY / MM / DD)

G: CHANGE OF FACILITY NAME / STREET ADDRESS

Facility Name	Name of Person Submitting Notification
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Complete this section if there has been a Canada Post change to the address of the diagnostic facility or if the facility name is to change.

Note: In order to relocate an existing Certificate of Approval, an application to amend the facility's approval to bill the Medical Services Plan is required. If this is the case, see the Relocation of an Existing Certificate of Approval, or Relocation with a Physical Expansion/Expansion of Services/Significant Change in Capacity, application form below:

Publicly-owned facility: <https://www2.gov.bc.ca/assets/gov/health/forms/1928bsave.pdf>

Privately-owned facility: <https://www2.gov.bc.ca/assets/gov/health/forms/1929bsave.pdf>

Effective Date of Change (YYYY / MM / DD)

Current Facility Information

Facility Name	Facility Number	Facility Payment Number
Current Facility Address (street address, city, postal code)		

New Information

New Facility Name
New Facility Address (street address, city, postal code)

Facility Name	Name of Person Submitting Notification
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Cease of Outpatient Diagnostic Facility Operations

Complete this section if a diagnostic facility will be closing, either temporarily or permanently.

Effective Date of Change (YYYY / MM / DD)

Facility Name	Facility Number	
Facility Address		
Type of Closure <input type="radio"/> Temporary* <input type="radio"/> Permanent	Effective Date of Closure (YYYY / MM / DD)	End Date (if applicable) (YYYY / MM / DD)
Reason for Closure		

* A temporary cease in operations may only extend to a maximum of 6 consecutive months. A lapse in service in excess of 6 consecutive months requires approval from the the ACDf, for additional information please refer to ACDf Policy (Part 4 - Lapse in Service).

DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION
APPENDIX A: CONFLICT OF INTEREST DECLARATION

To: Secretariat and Chair, ACDF

I have read and understood the Diagnostic Facility Conflict of Interest Policy (the "Policy"), and I undertake to be bound by the obligations contained therein.

I understand that it is my responsibility to report to the ACDF the information described in the Policy, and I undertake to do so.

I understand that the information I disclose will be held by the ACDF and that the information may be shared with members of the Medical Services Commission, as necessary.

I agree to inform the ACDF of any change in circumstances that may give rise to a conflict of interest with respect to a diagnostic facility, as soon as it is practicable.

ATTENTION: The person completing/signing this Declaration Form (the "Declarant") must be duly authorized to make the declaration on behalf of the person/entity submitting an application.

Name of diagnostic facility to which this conflict of interest declaration is in respect of:

Declarant
Name
Title
Date
Signature

DIAGNOSTIC OUTPATIENT SERVICES FACILITY APPLICATION

APPENDIX B: CONFLICT OF INTEREST DISCLOSURE

To: Secretariat and Chair, ACDF

Is there a (potential) conflict of interest to disclose in relation to the diagnostic facility? Check one:

- Yes, there is a (potential) conflict of interest to disclose in relation to the diagnostic facility. If yes, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.
- I am unsure if the circumstances constitute, or may constitute, a (potential) conflict of interest. If unsure, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.
- No, there is no conflict to interest to disclose in relation to the diagnostic facility.

If no conflict of interest is indicated, Appendix B must be completed by signing and completing the Appendix B signature block information.

ATTENTION: The person completing/signing this Disclosure Form (the “Declarant”) must be duly authorized to make the declaration/disclosure on behalf of the subject person/entity; that is the person who owns or intends to own the diagnostic facility (as applicable).

If applicable, provide full detail and circumstances that relate to potential conflicts of interest by completing Parts I and II.

APPENDIX B PART I

Append additional pages as necessary, to provide all relevant information.

Diagnostic Facility Name(s)	List the names of all relevant practitioners, family members, diagnostic facility owners (including the declarant) or business associates who hold or may hold a relevant financial or material interest	Any relevant affiliations or relationships with the owner or intended owner of the diagnostic facility and the details of any interest or benefit that may relate to a conflict of interest	Any other information, including dates, that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest

APPENDIX B PART II

In the space below, provide any additional information (not covered in Part I) that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest. Include any detail regarding proposed avoidance or mitigation measures relating to any actual or potential conflicts of interest. Append additional pages as necessary to provide all relevant information.

Name of diagnostic facility to which this conflict of interest disclosure is in respect of:

Declarant
Name
Title
Date
Signature