L'ORDRE DES PSYCHOLOGUES DE L'ONTARIO
THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO

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QUALITY ASSURANCE

PEER ASSISTED REVIEW: PRE-REVIEW INFORMATION QUESTIONNAIRE

To enable the Quality Assurance Coordinator to appropriately plan the review of your practice, please provide the following information, briefly describing your work and practice setting.

NOTE: If you practice in more than one setting, please copy this form and complete one for each setting.

Name: _____

Address: _____

Telephone: _____ Fax: _____

E-mail: _____

1. Type of setting, e.g., private practice, hospital, school, agency, facility, etc.

   _____

2. Number of years practicing in this particular type of setting? _____

3. Location of setting ◯ urban ◯ rural

4. Average percentage of time per month in setting _____

5. Number of active clients _____

6. Client population(s) served, e.g., children, couples, etc.

7. Services provided, e.g., therapy, assessment, research, administration, teaching, etc.

8. Areas of practice, e.g., anxiety, chronic pain, career planning, depression, etc.

9. Theoretical framework(s), e.g., psychoanalytic, cognitive-behavioural, systemic, etc.

10. Percentage of time working:

___ individually

___ with other psychology staff

___ with other professionals

___ with students

11. Percentage of time spent supervising:

____ CPO supervised practice members

____ non-regulated supervisees

____ regulated by another College

____ other, please describe _____

12. Description of how supervision is provided

Every effort will be made to schedule the review at a time that is convenient for both you and the reviewers. Please indicate your preferred days of the week and times of day. As well, please note any times within the next 3 months when you anticipate being unavailable for the review.

The College will be selecting one of the individuals who will be conducting the review. Please provide any information that you would like to have considered in the selection of the College Assessor.

Please indicate the name and address of another member of the College who has agreed to participate as a reviewer in the review of your practice, after having reviewed the "*Eligibility Requirements for a Member Nominated Reviewer*".

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Signature _____ Date: _____

To facilitate the review planning it would be appreciated if this questionnaire could be returned to Ms. Julie Hahn at the College, as soon as possible by e-mail (jhahn@cpo.on.ca), mail or fax (416-961-2635).