# Annual General Meeting of the Membership

Wednesday, June 25, 2025 | 8:00 a.m. |

# AGENDA

**CPSM Office**
**1000 – 1661 Portage Avenue**

| Time | | Item | | Action | Presenter | Page # |
|---|---|---|---|---|---|---|
| 5 min | 8:00 am | 1. | Opening Remarks and Land Acknowledgement | | Dr. Shenouda | |
| 0 min | 8:05 am | 2. | Agenda | Approval | Dr. Shenouda | |
| 5 min | 8:05 am | 3. | AGM Minutes June 26, 2024 | Approval | Dr. Shenouda | 5 |
| 5 min | 8:10 am | 4. | Financial Statements<br>i. CPSM Summary Financial Statements<br>ii. CPSM Financial Statements<br>iii. Manitoba Quality Assurance Program<br>iv. Manitoba Physician Public Register Program | Approval | Dr. Shenouda | 8 |
| 0 min | 8:15 am | 5. | Appointment of Auditors | Approval | Dr. Shenouda | 44 |
| 5 min | 8:15 am | 6. | Bylaw Amendments<br>i. Accredited Facilities Bylaw | Approval | Dr. Shenouda | 45 |
| 0 min | 8:20 am | 7. | Election Results | For Information | Dr. Shenouda | 70 |
| | | 8. | End Meeting | | Dr. Shenouda | |
| 20 min | | | Estimated time of sessions | | | |

# Regulated Health Professions Act

## Duty to serve the public interest

s. 10(1) A college must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest.

## CPSM Mandate

10(2) A college has the following mandate:

(a) to regulate the practice of the health profession and govern its members in accordance with this Act and the regulations and by-laws;
(b) to develop, establish and maintain standards of academic or technical achievement and qualification required for registration as a member and monitor compliance with and enforce those standards;
(c) to develop, establish and maintain standards of practice to enhance the quality of practice by members and monitor compliance with and enforce those standards;
(d) to develop, establish and maintain a continuing competency program for members to promote high standards of knowledge and skill;
(e) to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues;
(f) to work in consultation with the minister towards achieving access for the people of Manitoba to adequate numbers of qualified and competent members of the regulated health profession;
(g) to develop, establish and maintain programs that provide information about the health profession, and that assist persons in exercising their rights under this Act and the regulations, by-laws and code of ethics;
(h) to promote and enhance the college's relations with its members, other colleges, key stakeholders and the public;
(i) to promote inter-professional collaboration with other colleges;
(j) to administer the college's affairs and perform its duties and carry out its powers in accordance with this Act and the regulations and by-laws.

## CPSM Governance Policy – Governing Style and Code of Conduct:

### 1.1 General

Council recognizes its accountability to the people of Manitoba to carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest. To that end, Council will govern with an emphasis on strategic leadership, including a commitment to obtaining public and membership input, encouragement of diverse viewpoints, and clear distinction of Council and staff roles.

# Rules of the Annual General Meeting of the Membership Affairs of the College Bylaw Excerpts

## Meetings of Membership

### Annual meeting of the membership

60. Each calendar year, an annual meeting of the members of the College must be held in Manitoba, at a time and place to be determined by Council.

### Notice of meeting of the membership

65. For all annual general and special meetings of the membership:
    a. Council must provide at least 14 days notice of the meeting to each member of the College and to the public;
    b. notice to members must include:
        i. the place, date and time of the meeting, and
        ii. any resolutions proposed to be presented at the meeting; and
    c. notice to members and to the public may be given by posting a notice on the College website.

66. The accidental omission to give notice of a meeting to, or the non-receipt of a notice by, a person entitled to receive notice does not invalidate proceedings at the meeting.

### Quorum at meeting of the membership

67. A quorum for a meeting of members is eight voting members.

### Procedure at meeting of the membership

68. The President or in the absence of the President, the President-Elect or the Past-President, must preside over the meeting. In the absence of the President, President-Elect and Past-President, the members present must elect a chairperson from among Councillors present at the meeting.

69. The President must set the agenda for the annual general meeting of the members. The agenda must include the following items:
    a. Council reports relevant to the activities of the College;
    b. the CPSM's audited financial statement and report;
    c. any new Bylaws or Bylaw amendments approved by Council in the preceding year, which require membership approval; and
    d. the annual appointment of the auditors of the College.

## Voting at meeting of the membership

70. A member of the College in good standing present in person at the meeting and entitled to vote at the meeting has one vote.

71. Voting will be conducted by a show of hands, unless the chairperson considers it necessary to conduct a vote by ballot.

72. In case of a tie vote, the proposed resolution does not pass.

73. Any resolution passed at an annual or special meeting of members, except for a resolution confirming or varying a Bylaw, must be considered by Council at its next regularly scheduled meeting.

## Entitlement to vote at meeting of the membership

78. All regulated members and regulated associate members who attend a meeting of the membership in person are entitled to vote at the meeting, except members in the following classes:

a. Full - academic, visiting professor;
b. Full - non-practising;
c. Full - retired;
d. Provisional - restricted purpose;
e. Provisional - temporary locum;
f. Provisional - non-practising;
g. Provisional - retired;
h. Assessment candidate - specialty practice;
i. Assessment candidate - family practice;
j. Assessment candidate - re-entry to practice;
k. Educational - non-practising;
l. Physician assistant - restricted purpose;
m. Physician assistant - non-practising;
n. Clinical assistant- non-practising;
o. Physician assistant or clinical assistant retired.

## Procedural issues at members meeting

79. A dispute concerning the procedure to be followed at a meeting of members that is not provided for in the RHPA or Bylaws must be resolved in accordance with Roberts Rules of Order.

# Minutes of the Annual Meeting of the Membership June 26, 2024

A meeting of the Membership of The College of Physicians and Surgeons of Manitoba was held in-person on Wednesday, June 26, 2024, at the CPSM Office at 1661 Portage Avenue, Winnipeg, Manitoba with a virtual option via Zoom.

## 1. CALL TO ORDER

The meeting was called to order at 8:01 a.m. by the Chair of the meeting, Dr. Nader Shenouda.

REGISTRANTS:
- Dr. Nader Shenouda - President
- Dr. Kevin Convery
- Dr. Jacobi Elliott
- Dr. Charles Penner
- Dr. Wendy MacMillan-Wang
- Dr. Jennifer McNaught
- Dr. Rizwan Manji
- Dr. Chaitasi Intwala
- Dr. Lisa Monkman – Virtual
- Dr. Alewyn Vorster
- Dr. Roger Suss
- Dr. Guillaume Poliquin
- Dr. Sonja Bruin
- Dr. Nancy Dixon
- Dr. Marilyn Singer
- Dr. Anna Ziomek
- Dr. Ainslie Mihalchuk
- Dr. Karen Bullock Pries

MEMBERS OF THE PUBLIC:
- Mr. Allan Fineblit, Public Councillor
- Ms Marvelle McPherson, Public Councillor
- Ms Leanne Penny, Public Councillor
- Ms Leslie Agger, Public Councillor
- Ms Lynette Magnus, Public Councillor
- Mr. Neil Cohen

STAFF:
- Mr. Mike Triggs, General Counsel
- Mr. Paul Penner, Chief Operating Officer
- Mr. Jeremy de Jong, Interim Director, Registration
- Ms Karen Sorenson, Executive Assistant
- Ms Barbie Rodriques, Executive Assistant
- Ms Wendy Elias-Gagnon, Communications Officer

## 2. LAND ACKNOWLEDGMENT

Dr. Shenouda conveyed the CPSM Land Acknowledgment.

## 3. ADOPTION OF AGENDA

IT WAS MOVED BY DR. KAREN BULLOCK PRIES, SECONDED BY DR. RIZWAN MANJI:
*CARRIED*

That the agenda be approved.

## 4. ADOPTION OF MINUTES OF JUNE 28, 2023

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. KEVIN CONVERY:
*CARRIED*

That the minutes of June 28, 2023 be accepted as presented.

## 5. FINANCIAL STATEMENTS

The audited financial statements of the College of Physicians and Surgeons of Manitoba were reviewed, indicating the following:

| | |
|---|---|
| • Assets | $11,627,921 |
| • Liabilities | $5,241,806 |
| • Net Assets | $6,386,115 |
| • Revenues | $10,231,745 |
| • Expenses | $10,105,514 |
| • Net Income | $ 126,231 |

All financial statements contained unqualified opinions from BDO Canada LLP.

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. ALEWYN VORSTER:
*CARRIED*

That the following audited financial statements for the fiscal year May 1, 2023 to April 30, 2024 be approved as presented:

- The College of Physicians & Surgeons of Manitoba Summary Financial Statements
- The College of Physicians & Surgeons of Manitoba Financial Statements
- CPSM Manitoba Quality Assurance Program
- CPSM Public Register Profile Program

## 6. APPOINTMENT OF AUDITORS

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. JACOBI ELLIOTT:
*CARRIED*

The registrants approve BDO Canada LLP be appointed as auditors for all CPSM accounts in the forthcoming fiscal year 2024/2025 as recommended by the Finance, Audit and Risk Management Committee.

## 7. BYLAW AMENDMENTS

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. JENNIFER MCNAUGHT:
*CARRIED*

The Membership approve amendments to the CPSM Affairs of the College Bylaw as presented.

**8. ELECTION RESULTS**

Congratulations were extended to the following:

Elected in the Winnipeg Electoral District for a four-year term
- Dr. Rizwan Manji
- Dr. Jennifer McNaught
- Dr. Chaitasi Intwala

Elected in the West Electoral District for a four-year term
- Dr. Alewyn Vorster

Elected as the Regulated Associate Registrant for a one-year term
- Dr. Wendy MacMillan-Wang

A thank you was extended to the outgoing councillors:
- Dr. Norman McLean
- Dr. Roger Suss
- Dr. Heather Smith
- Mr. Chris Barnes

Dr. Shenouda welcomed/noted the following CPSM Staff changes:
- Dr. Sonji Bruin as Interim Director Quality Department
- Dr. Nancy Dixon, Interim Director Complaints and Investigations Department
- Mr. Jeremy de Jong as Interim Director Registration Department

There being no further business, the meeting ended at 8:15 a.m.

_____
Dr. N. Shenouda, President

_____
Dr. A. Ziomek, Registrar

# ANNUAL GENERAL MEETING OF THE MEMBERSHIP
# JUNE 25, 2025
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** Annual Financial Statements

## BACKGROUND:

BDO conducted audits of CPSM's 2024/25 financial statements. In BDO's opinion the financial statements present fairly, in all material respects, the financial position of CPSM as at April 30, 2025, and its results of operations and its cash flows for the year then ended in accordance with Canadian Accounting Standards for Not-for-Profit Organizations.

At its June 4th, 2025 meeting, the Finance, Audit & Risk Management Committee passed the motion to recommend to Council acceptance of all CPSM audited financial statements for the fiscal year May 1, 2024 through April 30, 2025.

## MOTION:

**NOTICE IS HEREBY GIVEN THAT AT THE ANNUAL GENERAL MEETING OF THE MEMBERSHIP OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 25, 2025, DR. CHARLES PENNER, CHAIRPERSON OF THE FINANCE, AUDIT AND RISK MANAGEMENT COMMITTEE, WILL MOVE THAT:**

The following financial statements for the fiscal year May 1, 2024 to April 30, 2025 be accepted as presented:

- CPSM Summary Financial Statements, ***Appendix A***
- CPSM Financial Statements, ***Appendix B***
- CPSM Manitoba Quality Assurance Program, ***Appendix C***
- CPSM Manitoba Physician Public Register Program, ***Appendix D***

**Notice for Motion Briefing Note prepared by: Mr. Paul Penner, Chief Financial Officer**

# Independent Auditor's Report on the Summary Financial Statements

**To the Council of the The College of Physicians and Surgeons of Manitoba**

**Opinion**

The summary financial statements, which comprise the summary statement of financial position as at April 30, 2025, and the summary statement of operations for the year then ended, and related note, are derived from the audited financial statements of The College of Physicians and Surgeons of Manitoba (the "Organization") for the year ended April 30, 2025.

In our opinion, the accompanying summary financial statements are a fair summary of the audited financial statements, on the basis described in the Note to the summary financial statements.

**Summary Financial Statements**

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements and the auditor's report thereon.

**The Audited Financial Statements and Our Report Thereon**

We expressed an unmodified audit opinion on the audited financial statements in our report dated June ___, 2025.

**Management's Responsibility for the Summary Financial Statements**

Management is responsible for the preparation of a summary of the audited financial statements in accordance with the Note to the summary financial statements.

**Auditor's Responsibility**

Our responsibility is to express an opinion on whether the summary financial statements are a fair summary of the audited financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, *Engagements to Report on Summary Financial Statements*.

Chartered Professional Accountants

Winnipeg, Manitoba
June ___, 2025

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Summary Statement of Financial Position

| As at April 30 | 2025 | 2024 |
|---|---|---|
| **Assets** | | |
| **Current Assets** | | |
| Cash and bank | **$ 6,179,751** | $ 5,471,430 |
| Investments | **2,214,943** | 2,241,825 |
| Accounts receivable | **97,991** | 80,559 |
| Prepaid expenses | **225,836** | 251,331 |
| | **8,718,521** | 8,045,145 |
| **Investments** | **3,277,331** | 3,174,999 |
| **Capital assets** | **354,866** | 306,672 |
| **Intangible assets** | **50,553** | 101,105 |
| | **$ 12,401,271** | $ 11,627,921 |
| **Liabilities and Net Assets** | | |
| **Current Liabilities** | | |
| Accounts payable and accrued liabilities | **$ 340,085** | $ 321,250 |
| Accrued pre-retirement leave benefits | **89,597** | 273,261 |
| Accrued vacation | **134,086** | 174,544 |
| Deferred program revenue | **335,692** | 351,368 |
| Deferred registrant dues revenue | **4,360,476** | 4,121,383 |
| | **5,259,936** | 5,241,806 |
| **Net Assets** | | |
| Unrestricted | **2,654,916** | 1,693,338 |
| Invested in capital and intangible assets | **405,419** | 407,777 |
| Internally restricted | **4,081,000** | 4,285,000 |
| | **7,141,335** | 6,386,115 |
| | **$ 12,401,271** | $ 11,627,921 |

Approved on behalf of Council

_____ President

_____ Registrar

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Summary Statement of Operations

| For the year ended April 30 | 2025 | 2024 |
|---|---|---|
| **Revenue** | | |
| Physician and resident license fees | **$ 8,088,036** | $ 7,404,617 |
| Educational register fees | **103,476** | 98,963 |
| Clinical assistant license fees | **105,085** | 87,512 |
| Physician assistant license fees | **74,597** | 72,322 |
| Medical corporation fees | **595,010** | 547,815 |
| Other fees and income | **1,044,352** | 794,255 |
| Interest income | **246,315** | 257,243 |
| Investment income | **212,325** | 137,220 |
| Government funded program revenue | **984,813** | 831,798 |
| | **11,454,009** | 10,231,745 |
| **Expenses** | | |
| Governance | **143,475** | 146,790 |
| Qualifications | **829,683** | 994,598 |
| Complaints and investigations | **2,635,392** | 2,542,702 |
| Quality | **2,560,689** | 2,384,392 |
| Operations and general administration | **2,840,528** | 2,561,730 |
| Information technology | **704,032** | 643,052 |
| Government funded program expenses | **984,990** | 832,250 |
| | **10,698,789** | 10,105,514 |
| **Excess of revenue over expenses for the year** | **$ 755,220** | $ 126,231 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Note to the Summary Financial Statements

**For the year ended April 30, 2025**

### 1. Basis of Presentation

Management has prepared the summary financial statements from the Organization's April 30, 2025 audited financial statements. The complete financial statements, including notes to the financial statements and the independent auditor's report, are available upon request by contacting the Organization's office.

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

## Financial Statements

**For the year ended April 30, 2025**

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

## Financial Statements

**For the year ended April 30, 2025**

**Contents**

# Independent Auditor's Report

**To the Council of the The College of Physicians and Surgeons of Manitoba**

**Opinion**

We have audited the financial statements of the **The College of Physicians and Surgeons of Manitoba** (the "Organization"), which comprise the statement of financial position as at April 30, 2025, and the statement of operations, the statement of changes in net assets, and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization as at April 30, 2025, and its results of operations and its cash flows for the year then ended in accordance with Canadian Accounting Standards for Not-for-Profit Organizations.

**Basis for Opinion**

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the Organization in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

**Responsibilities of Management and Those Charged with Governance for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian Accounting Standards for Not-for-Profit Organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Organization's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Organization or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Organization's financial reporting process.

**Auditor's Responsibilities for the Audit of the Financial Statements**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Organization's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Organization to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Chartered Professional Accountants

Winnipeg, Manitoba
June ___, 2025

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Statement of Financial Position

| As at April 30 | 2025 | 2024 |
|---|---|---|
| **Assets** | | |
| **Current Assets** | | |
| Cash and bank | **$ 6,179,751** | $ 5,471,430 |
| Investments (Note 3) | **2,214,943** | 2,241,825 |
| Accounts receivable | **97,991** | 80,559 |
| Prepaid expenses | **225,836** | 251,331 |
| | **8,718,521** | 8,045,145 |
| **Investments** (Note 3) | **3,277,331** | 3,174,999 |
| **Capital assets** (Note 4) | **354,866** | 306,672 |
| **Intangible assets** (Note 5) | **50,553** | 101,105 |
| | **$ 12,401,271** | $ 11,627,921 |
| **Liabilities and Net Assets** | | |
| **Current Liabilities** | | |
| Accounts payable and accrued liabilities | **$ 340,085** | $ 321,250 |
| Accrued pre-retirement leave benefits (Note 6) | **89,597** | 273,261 |
| Accrued vacation | **134,086** | 174,544 |
| Deferred program revenue (Schedule 1) | **335,692** | 351,368 |
| Deferred registrant dues revenue | **4,360,476** | 4,121,383 |
| | **5,259,936** | 5,241,806 |
| **Contingencies** (Note 8) | | |
| **Commitments** (Note 9) | | |
| **Net Assets** | | |
| Unrestricted | **2,654,916** | 1,693,338 |
| Invested in capital and intangible assets | **405,419** | 407,777 |
| Internally restricted (Note 10) | **4,081,000** | 4,285,000 |
| | **7,141,335** | 6,386,115 |
| | **$ 12,401,271** | $ 11,627,921 |

Approved on behalf of Council

_____ President

_____ Registrar

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Statement of Operations

| For the year ended April 30 | 2025 | 2024 |
|---|---|---|
| **Revenue** | | |
| Physician and resident license fees | **$ 8,088,036** | $ 7,404,617 |
| Educational register fees | **103,476** | 98,963 |
| Clinical assistant license fees | **105,085** | 87,512 |
| Physician assistant license fees | **74,597** | 72,322 |
| Medical corporation fees | **595,010** | 547,815 |
| Other fees and income | **1,044,352** | 794,255 |
| Interest income | **246,315** | 257,243 |
| Investment income | **212,325** | 137,220 |
| Government funded program revenue (Schedule 1) | **984,813** | 831,798 |
| | **11,454,009** | 10,231,745 |
| **Expenses** (Schedule 2) | | |
| Governance | **143,475** | 146,790 |
| Qualifications | **829,683** | 994,598 |
| Complaints and investigations | **2,635,392** | 2,542,702 |
| Quality | **2,560,689** | 2,384,392 |
| Operations and general administration | **2,840,528** | 2,561,730 |
| Information technology | **704,032** | 643,052 |
| Government funded program expenses (Schedule 1) | **984,990** | 832,250 |
| | **10,698,789** | 10,105,514 |
| **Excess of revenue over expenses for the year** | **$ 755,220** | $ 126,231 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Statement of Changes in Net Assets

**For the year ended April 30, 2025**

| | Unrestricted | Invested in Capital and Intangible Assets | Internally Restricted | Total 2025 |
|---|---|---|---|---|
| **Net assets**, beginning of year | **$ 1,693,338** | **$ 407,777** | **$ 4,285,000** | **$ 6,386,115** |
| **Excess (deficiency) of revenue over expenses** | **917,360** | **(162,140)** | **-** | **755,220** |
| **Purchase of capital assets** | **(159,782)** | **159,782** | **-** | **-** |
| **Interfund transfer from internally restricted** | **204,000** | **-** | **(204,000)** | **-** |
| **Net assets**, end of year | **$ 2,654,916** | **$ 405,419** | **$ 4,081,000** | **$ 7,141,335** |

| | Unrestricted | Invested in Capital and Intangible Assets | Internally Restricted | Total 2024 |
|---|---|---|---|---|
| Net assets, beginning of year | $ 1,698,780 | $ 558,104 | $ 4,003,000 | $ 6,259,884 |
| Excess (deficiency) of revenue over expenses | 341,852 | (215,621) | - | 126,231 |
| Purchase of capital assets | (65,294) | 65,294 | - | - |
| Transfer to internally restricted | (282,000) | - | 282,000 | - |
| Net assets, end of year | $ 1,693,338 | $ 407,777 | $ 4,285,000 | $ 6,386,115 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Statement of Cash Flows

| For the year ended April 30 | 2025 | 2024 |
|---|---|---|
| **Cash provided by (applied to):** | | |
| **Operating Activities** | | |
| Excess of revenue over expenses for the year | **$ 755,220** | $ 126,231 |
| Adjustments for items not affecting cash | | |
| Unrealized gain on investments | **(73,290)** | - |
| Change in accrued interest receivable on investments | **(2,160)** | (345) |
| Amortization of capital and intangible assets | **162,140** | 215,621 |
| | **841,910** | 341,507 |
| Changes in non-cash operating working capital balances | | |
| Accounts receivable | **(17,432)** | 19,468 |
| Prepaid expenses | **25,495** | (62,452) |
| Accrued payable and accrued liabilities | **18,835** | 94,690 |
| Accrued pre-retirement leave benefits | **(183,664)** | (31,611) |
| Accrued vacation | **(40,458)** | 59,632 |
| Deferred program revenue | **(15,676)** | 187,847 |
| Deferred registrant dues revenue | **239,093** | 449,900 |
| | **868,103** | 1,058,981 |
| **Investing Activities** | | |
| Purchase of capital assets | **(159,782)** | (65,294) |
| **Financing Activities** | **-** | - |
| **Net increase in cash and bank during the year** | **708,321** | 993,687 |
| **Cash and bank**, beginning of year | **5,471,430** | 4,477,743 |
| **Cash and bank**, end of year | **$ 6,179,751** | $ 5,471,430 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Notes to Financial Statements

**For the year ended April 30, 2025**

### 1. Nature of Operations

The College of Physicians and Surgeons of Manitoba ("Organization") is the statutory body responsible for maintaining standards of medical practice within Manitoba through the administration of The Regulated Health Professions Act, Regulations, and related By-Laws, including the Code of Conduct.

The Organization's mandate is to protect the public as consumers of medical care and promote the safe and ethical delivery of quality medical care by physicians in Manitoba. The Organization is incorporated under the laws of the Province of Manitoba and is exempt from taxes under the Income Tax Act.

### 2. Summary of Significant Accounting Policies

a. Basis of Accounting

The financial statements are prepared in accordance with Canadian Accounting Standards for Not-for-Profit Organizations ("ASNPO").

b. Revenue Recognition

The Organization follows the deferral method of accounting for contributions.

Externally restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Until such time, externally restricted contributions are reported as deferred revenue. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Registrants are charged an annual license fee based on the period from November 1st to October 31st, and these fees are recognized into income on a straight-line basis over this 12 month period. Deferred revenue represents the registrants' fees for the six month period from May to October which will be recognized as revenue in the subsequent fiscal year.

Other fees and revenue are recognized as revenue when the related registration or licensing has occurred or the related services have been performed and collection is reasonably assured.

Investment income is recognized on an accrual basis as earned.

**2. Summary of Significant Accounting Policies (continued)**

c. Capital Assets

Purchased capital assets are recorded at cost. Contributed capital assets are recorded at fair value at the date of contribution if fair value can be reasonably determined. Amortization is based on the estimated useful life of the asset and is calculated on a straight-line basis as follows:

| | |
|---|---|
| Computer equipment | 5 years |
| Office furniture and equipment | 5 years |
| Leasehold improvements | 10 years |

d. Intangible Assets

Intangible assets are recorded at cost. Contributed intangible assets are recorded at fair value at the date of contribution if fair value can be reasonably determined.

Intangible assets recorded in the statement of financial position represent the registrant application software, electronic document and records management system, and other software which are being amortized on a straight-line basis over 5 years.

e. Financial Instruments

Financial assets and financial liabilities are initially recognized at fair value when the Organization becomes a party to the contractual provisions of the financial instrument. Subsequently, all financial instruments are measured at amortized cost. Financial assets and financial liabilities originated or exchanged in related party transactions, except for those that involve parties whose sole relationship with the Organization is in the capacity of management, are initially recognized at cost.

The cost of a financial instrument in a related party transaction depends on whether the instrument has repayment terms. The cost of financial instruments with repayment terms is determined using its undiscounted cash flows, excluding interest and dividend payments, less any impairment losses previously recognized by the transferor. The cost of financial instruments without repayment terms is determined using the consideration transferred or received by the Organization in the transaction.

Transaction costs related to financial instruments are added to the carrying value of the asset or netted against the carrying value of the liability and are then recognized over the expected life of the instrument using the straight-line method. Any premium or discount related to an instrument measured at amortized cost is amortized over the expected life of the item using the straight-line method and recognized in net earnings as interest income or expense.

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Notes to Financial Statements

**For the year ended April 30, 2025**

**2. Summary of Significant Accounting Policies (continued)**

e. Financial Instruments (continued)

The Organization recognizes in net earnings an impairment loss, if any, when it determines that a significant adverse change has occurred during the period in the expected timing or amount of future cash flows. When the extent of impairment of a previously written-down asset decreases and the decrease can be related to an event occurring after the impairment was recognized, the previously recognized impairment loss shall be reversed in net earnings in the period the reversal occurs.

f. Use of Estimates

The preparation of financial statements in conformity with Canadian Accounting Standards for Not-for-Profit Organizations requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenue and expense during the period. Significant estimates include the useful life of both the capital and intangible assets, the allowance for doubtful accounts, which was estimated to be $144,308 at April 30, 2025 (2024 - $144,308), and the accrued for pre-retirement leave benefits. Actual results could differ from these estimates.

**3. Investments**

| | **2025** | 2024 |
|---|---|---|
| Portfolio of fixed rate investments, bearing effective interest rate at 4% maturing August 2025 and 2026, including interest receivable of $93,984 ($91,825 in 2024). | **$ 3,243,984** | $ 3,241,824 |
| Principal protected note, generating fixed interest payments of $0.50 per deposit note plus variable interest payment of greater of 85% of the share portfolio performance, as defined in the agreement, and nil, maturing on December 15, 2028. | **1,175,000** | 1,175,000 |
| Principal Protected Note, generating fixed interest payments of $0.50 per deposit note plus variable interest payment of greater of 85% of the share portfolio performance, as defined in the agreement and nil, maturing on January 10, 2029. | **1,073,290** | 1,000,000 |
| | **5,492,274** | 5,416,824 |
| Less: Portion presented as current assets | **(2,214,943)** | (2,241,825) |
| | **$ 3,277,331** | $ 3,174,999 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Notes to Financial Statements

**For the year ended April 30, 2025**

### 3. Investments (continued)

As at April 30, 2025 the market prices for the Principal Protected Notes were 96.703 and 107.329 respectively (86.179 and 89.201 respectively in 2024). The deposit notes guarantee the principal amount of the investment and therefore the Organization is not required to recognize any unrealized losses when fair value falls below book value, but is required to record unrealized gains when fair value exceeds book value.

### 4. Capital Assets

| | 2025 | | | 2024 | | |
|---|---|---|---|---|---|---|
| | **Cost** | **Accumulated Amortization** | **Net Book Value** | Cost | Accumulated Amortization | Net Book Value |
| Computer equipment | **$ 1,122,088** | **$ 927,733** | **$ 194,355** | $ 1,064,191 | $ 854,941 | $ 209,250 |
| Office furniture and equipment | **659,963** | **537,563** | **122,400** | 591,248 | 499,522 | 91,726 |
| Leasehold improvements | **280,154** | **242,043** | **38,111** | 246,984 | 241,288 | 5,696 |
| | **$ 2,062,205** | **$ 1,707,339** | **$ 354,866** | $ 1,902,423 | $ 1,595,751 | $ 306,672 |

### 5. Intangible Assets

| | 2025 | | | 2024 | | |
|---|---|---|---|---|---|---|
| | **Cost** | **Accumulated Amortization** | **Net Book Value** | Cost | Accumulated Amortization | Net Book Value |
| Registrant application software | **$ 878,793** | **$ 878,793** | **$ -** | $ 878,793 | $ 878,793 | $ - |
| Other software | **252,761** | **202,208** | **50,553** | 252,761 | 151,656 | 101,105 |
| | **$ 1,131,554** | **$ 1,081,001** | **$ 50,553** | $ 1,131,554 | $ 1,030,449 | $ 101,105 |

### 6. Accrued Pre-retirement Leave Benefits

The Organization provides pre-retirement benefits to those who meet certain criteria. The policy has been in effect since 2008 and provides benefits for registrars and other salaried employees once they meet either of the following criteria: 60 years old and have completed 10 years of continuous employment with the Organization, or 55 years old and 25 years of continuous employment. The estimated liability related to the pre-retirement leave benefits is assessed on an annual basis and any change in the liability is recorded as an expense in the statement of operations.

## 7. Pension Plan

The Organization has a defined contribution pension plan for its employees. For employees hired prior to May 1, 2016, the Organization contributes 8% of salaries for eligble employees. For employees hired on or after May 1, 2016, the Organization contributes 4% of salaries and eligible employees contribute a mandatory 4%. The amount expensed during the year related to this pension plan was $322,724 ($321,789 in 2024).

## 8. Contingencies

Complaints and Claims - The nature of the Organization's activities is such that there is usually litigation pending or in prospect at any time. As at the date of approval of these financial statements, there were no known claims.

Inquiries and Investigations - The Organization has certain incomplete inquiries and investigations as at April 30, 2025. All costs associated with these actions are not determinable at the time of the preparation of these financial statements and will be reflected as expenses and cost recovery fees, if any, in the period they are known and can be reasonably measured. A reserve for potential inquiry costs is established at year-end based on extraordinary number of ongoing and anticipated inquiry cases known at that time and using estimates according to the recent historical cost analysis performed by the Organization.

With regard to completed inquiries and investigations, the Organization attempts to recover costs from those registrants who are found guilty. The outcome of these efforts are unknown at this time and will be reflected in the financial statements when these recoveries (if any) are known, can be reasonably measured and collection is likely.

## 9. Commitments

The Organization has a lease for its office space over a term of 10 years and 3 months which commenced on August 1, 2021 and ends on October 31, 2031. Total basic lease payments over the next 5 years ending April 30 and thereafter are as follows:

| | |
|---|---|
| 2026 | $ 238,387 |
| 2027 | 248,752 |
| 2028 | 248,752 |
| 2029 | 248,752 |
| 2030 | 248,752 |
| Thereafter, in aggregate | 352,399 |
| Total | $ 1,585,794 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Notes to Financial Statements

**For the year ended April 30, 2025**

### 10. Internally Restricted Net Assets

Net assets have been internally restricted by the Council of the Organization as follows:

| | 2025 | 2024 |
|---|---|---|
| Reserve for wind-up costs | **$ 3,293,000** | $ 3,293,000 |
| Reserve for potential inquiry costs | **288,000** | 492,000 |
| Reserve for IT projects | **500,000** | 500,000 |
| | **$ 4,081,000** | $ 4,285,000 |

The internally restricted net assets of the Organization are governed by Section 1.8 - Restricted Accounts in the Accumulated Surplus of the Financial Management Policy of the Council.

### 11. Financial Instruments Risk Management

The Organization, as part of its operations, carries a number of financial instruments. It is management's opinion that the Organization is not exposed to significant interest rate, currency, credit, liquidity or other price risks arising from these financial instruments except as otherwise disclosed.

*Credit Risk*

Credit risk is the risk that a financial loss will be incurred due to the failure of a counterparty to discharge its contractual commitment or obligation to the Organization. Financial instruments that potentially subject the Organization to significant concentrations of credit risk consist primarily of cash and bank, investments and receivables. The Organization is exposed to concentration risk through cash and bank held in excess of insured limits from time to time. The Organization is exposed to credit risk from registrants. An allowance for doubtful accounts is established based upon factors surrounding the credit risk of specific receivable accounts, historical trends and other information.

The Organization's credit risk policies set out the minimum requirements for management of credit risk in a variety of transactional and portfolio management contexts. Its credit risk policies comprise the following:

- Investment guidelines are in place that require only the purchase of investment grade assets and minimize concentration of assets in any single geographic area, industry and company;
- Credit ratings are determined by recognized external credit rating agencies; and
- Portfolios are monitored continuously, and reviewed monthly by the Registrar and Chief Operating Officer. The Finance, Audit and Risk Management Committee receives reports quarterly during the year.

## 11. Financial Instruments Risk Management (continued)

*Credit Risk (continued)*

With respect to credit risk, investment objectives are discussed with a Professional Investment Advisor. Management receives monthly reports summarizing investment activity, in order to monitor credit risk for the Organization. There has been no change in the Organization's exposure to credit risk from the prior year.

*Interest Rate Risk*

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in the interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as price risk. The Organization is exposed to price risk with respect to its investment portfolio of bonds and other fixed rate investments, which are measured at fair value.

The Organization is exposed to interest rate cash flow risk with respect to interest bearing investments. As at April 30, 2025, the Organization holds $5,492,274 (2024 - $5,416,824) of investments with fixed rates of interest. As a result, the impact of interest rate changes on cash flows has been substantially mitigated. There has been no change in the Organization's exposure to interest rate risk from the prior year.

*Liquidity Risk*

Liquidity risk is the risk that the Organization encounters difficulty in meeting its obligations associated with financial liabilities. Liquidity risk includes the risk that, as a result of operational liquidity requirements, the Organization will not have sufficient funds to settle a transaction on the due date, will be forced to sell financial assets at a value which is less than what they are worth, or may be unable to settle or recover a financial asset. Liquidity risk arises from accounts payable. The Organization manages its liquidity to maintain adequate levels of working capital to ensure its obligations can be met when they fall due. There has been no change in the Organization's exposure to liquidity risk from the prior year.

## 12. Allocated Expenses

The Organization allocates certain common expenses among its programs as they represent indirect program costs. Examples of common costs which are allocated include office rent, insurance, IT support, amortization and others. The allocation is mainly based on program business volume. The allocated expenses by program are presented in Schedule 2 - Program Expenses by Nature.

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Schedule 1 - Programs Administered by the Organization

**For the year ended April 30, 2025**

| | Deferred Revenue (Receivable) Beginning of Year | Cash Received in Current Year | Revenue Available for Programming | Deferred Revenue (Receivable) End of Year | 2025 Gross Program Revenue | 2025 Gross Program Expenses | 2024 Gross Program Revenue | 2024 Gross Program Expenses |
|---|---|---|---|---|---|---|---|---|
| Manitoba Quality Assurance Program (MANQAP) | **$ 340,584** | **$ 954,137** | **$ 1,294,721** | **$ 324,908** | **$ 969,813** | **$ 969,813** | $ 816,798 | $ 816,798 |
| Manitoba Physician Public Register Program | **(1,005)** | **15,177** | **14,172** | **(1,005)** | **15,000** | **15,177** | 15,000 | 15,452 |
| Substance Use and Addictions Program (SUAP) | **11,789** | **-** | **-** | **11,789** | **-** | **-** | - | - |
| | **$ 351,368** | **$ 969,314** | **$ 1,308,893** | **$ 335,692** | **$ 984,813** | **$ 984,990** | $ 831,798 | $ 832,250 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Schedule 2 - Program Expenses by Nature

**For the year ended April 30, 2025**

| | Governance | Qualifications | Complaints and Investigations | Quality | Operations and General Administration | Information Technology | Government-Funded Programs | 2025 | 2024 |
|---|---|---|---|---|---|---|---|---|---|
| Employee costs | $ - | $ 485,575 | $ 1,956,857 | $ 1,810,624 | $ 2,353,361 | $ 604,726 | $ 634,292 | $ 7,845,435 | $ 7,377,176 |
| Committee meetings | 91,061 | 12,472 | 74,686 | 94,853 | 66,853 | - | 18,668 | 358,593 | 325,009 |
| Professional fees | 43,150 | - | 167,497 | 251,397 | 34,382 | - | 162,146 | 658,572 | 654,421 |
| Service fees | 3,624 | - | 4,216 | 30,540 | 6,527 | 240,381 | - | 285,288 | 283,588 |
| Legal | - | 674 | 44,322 | - | 20,524 | - | - | 65,520 | 15,244 |
| Building and occupancy costs | - | 282 | 2,940 | 2,276 | 535,461 | 1,246 | 69,949 | 612,154 | 593,511 |
| Office | 5,640 | 208,267 | 25,540 | 18,451 | 266,950 | 175,849 | 10,390 | 711,087 | 640,944 |
| Amortization | - | - | - | - | 38,796 | 123,344 | - | 162,140 | 215,621 |
| | 143,475 | 707,270 | 2,276,058 | 2,208,141 | 3,322,854 | 1,145,546 | 895,445 | 10,698,789 | 10,105,514 |
| Allocated expenses | - | 122,413 | 359,334 | 352,548 | (482,326) | (441,514) | 89,545 | - | - |
| Total expenses | $ 143,475 | $ 829,683 | $ 2,635,392 | $ 2,560,689 | $ 2,840,528 | $ 704,032 | $ 984,990 | $ 10,698,789 | $ 10,105,514 |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Manitoba Quality Assurance Program (MANQAP)

## Financial Statements
**For the year ended April 30, 2025**

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

## Manitoba Quality Assurance Program (MANQAP)
## Financial Statements
**For the year ended April 30, 2025**

**Contents**

# Independent Auditor's Report

**To the Council of the The College of Physicians and Surgeons of Manitoba**

**Opinion**

We have audited the financial statements of the Manitoba Quality Assurance Program ("MANQAP" or the "Program") administered by **The College of Physicians and Surgeons of Manitoba** (the "Organization"), which comprise the statement of financial position as at April 30, 2025, and the statement of program operations and changes in net assets for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements for the year ended April 30, 2025 are prepared, in all material respects, in accordance with the basis of accounting described in the notes to the financial statements.

**Basis for Opinion**

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the Organization in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

**Emphasis of Matter - Basis of Accounting**

We draw attention to Note 2b to the financial statements, which describes the basis of accounting. The financial statements are prepared to assist the Organization in complying with the requirements of its funding agreement with the Government of Manitoba as represented by Manitoba Health, Seniors and Long-Term Care (the "Agreement") dated October 24, 2024. As a result, the financial statements may not be suitable for another purpose. Our opinion is not modified in respect of this matter.

**Responsibilities of Management and Those Charged with Governance for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the financial reporting provisions of the Agreement, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Those charged with governance are responsible for overseeing the Organization's financial reporting process.

**Auditor's Responsibilities for the Audit of the Financial Statements**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Chartered Professional Accountants

Winnipeg, Manitoba
June ___, 2025

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Manitoba Quality Assurance Program (MANQAP)
## Statement of Financial Position

| As at April 30 | 2025 | 2024 |
|---|---|---|
| **Assets** | | |
| **Current Assets** | | |
| Cash and bank | **$ 321,377** | $ 337,053 |
| **Liabilities and Net Assets** | | |
| **Current Liabilities** | | |
| Deferred program revenue | **$ 324,908** | $ 340,584 |
| **Net Assets** | | |
| Unrestricted (deficit) | **(3,531)** | (3,531) |
| | **$ 321,377** | $ 337,053 |

Approved on behalf of Council:

_____ President

_____ Registrar

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Manitoba Quality Assurance Program (MANQAP)
## Statement of Program Operations and Changes in Net Assets

| For the year ended April 30 | 2025 Budget | 2025 Actual | 2024 Actual |
|---|---|---|---|
| **Revenue** | | | |
| Manitoba Health | **$ 915,674** | **$ 931,676** | $ 795,563 |
| Other - Private laboratory survey | **-** | **38,137** | 21,235 |
| | **915,674** | **969,813** | 816,798 |
| **Expenses** | | | |
| Building and occupancy costs | **67,581** | **69,949** | 64,110 |
| Committee meetings | **7,728** | **18,668** | 5,007 |
| Employee costs | **625,660** | **621,292** | 565,074 |
| Office expenses | **8,085** | **10,390** | 9,103 |
| Overhead | **83,243** | **88,165** | 74,254 |
| Professional fees | **123,377** | **161,349** | 99,250 |
| | **915,674** | **969,813** | 816,798 |
| **Excess of revenue over expenses for the year** | **-** | **-** | - |
| **Net assets (deficit),** beginning of year | **-** | **(3,531)** | (3,531) |
| **Net assets (deficit),** end of year | **$ -** | **$ (3,531)** | $ (3,531) |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Manitoba Quality Assurance Program (MANQAP)
## Notes to Financial Statements

**For the year ended April 30, 2025**

### 1. Nature of the Program

The College of Physicians and Surgeons of Manitoba (the "Organization") operates the Manitoba Quality Assurance Program ("Program") on behalf of the Government of Manitoba as represented by the Manitoba Health, Seniors and Long-term Care. The purpose of the program is to provide standards, inspect diagnostic facilities, and monitor compliance for the purpose of accreditation. In accordance with the "Accredited Facilities" Bylaw of the Organization, facility directors must be compliant with this Bylaw and all relevant standards as established by the Organization.

This Program and its financial statements is one segment of the overall operations of the Organization.

### 2. Summary of Significant Accounting Policies

a. Basis of Presentation

The financial statements present the statement of financial position and the statement operations and changes in net assets of the Program administered by the Organization and do not represent all assets, liabilities, net assets and operations of the Organization.

b. Basis of Accounting

These financial statements have been prepared in accordance with the financial reporting provisions of section F of schedule A of the funding agreement with the Government of Manitoba as represented by Manitoba Health, Seniors and Long-Term Care (the "Agreement") dated October 24, 2024, using the recognition and measurement principles of Canadian Accounting Standards for Not-for-Profit Organizations.

c. Revenue Recognition

The Program follows the deferral method of accounting for contributions. Externally restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Until such time, externally restricted contributions are reported as deferred revenue. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Other revenue are recognized as revenue when the related services have been performed and collection is reasonably assured.

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

**Manitoba Physician Public Register Program**

## Financial Statements

**For the year ended April 30, 2025**

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Manitoba Physician Public Register Program

### Financial Statements
**For the year ended April 30, 2025**

**Contents**

# Independent Auditor's Report

**To the Council of the The College of Physicians and Surgeons of Manitoba**

**Opinion**

We have audited the financial statements of the Manitoba Physician Public Register Program (the "Program") administered by **The College of Physicians and Surgeons of Manitoba** (the "Organization"), which comprise the statement of financial position as at April 30, 2025, and the statement of operations and changes in net assets for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements for the year ended April 30, 2025 are prepared, in all material respects, in accordance with the basis of accounting described in the notes to the financial statements.

**Basis for Opinion**

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the Organization in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

**Emphasis of Matter - Basis of Accounting**

We draw attention to Note 2b to the financial statements, which describes the basis of accounting. The financial statements are prepared to assist the Organization in complying with the requirements of its funding agreement with the Government of Manitoba as represented by Manitoba Health, Seniors and Long-Term Care (the "Agreement") dated October 3, 2024. As a result, the financial statements may not be suitable for another purpose. Our opinion is not modified in respect of this matter.

**Responsibilities of Management and Those Charged with Governance for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the financial reporting provisions of the Agreement, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Those charged with governance are responsible for overseeing the Organization's financial reporting process.

**Auditor's Responsibilities for the Audit of the Financial Statements**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Chartered Professional Accountants

Winnipeg, Manitoba
June ___, 2025

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

## Manitoba Physician Public Register Program
## Statement of Financial Position

| As at April 30 | 2025 | 2024 |
|---|---|---|
| **Assets** | | |
| **Current Assets** | | |
| Receivable - Government program | **$ 1,005** | $ 1,005 |
| **Liabilities and Net Assets** | | |
| **Current Liabilities** | | |
| Cash deficiency | **$ 2,054** | $ 1,877 |
| **Net Assets** | | |
| Unrestricted (deficit) | **(1,049)** | (872) |
| | **$ 1,005** | $ 1,005 |

Approved on behalf of Council:

_____ President

_____ Registrar

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

## Manitoba Physician Public Register Program
## Statement of Program Operations and Changes in Net Assets

| For the year ended April 30 | 2025 | 2024 |
|---|---|---|
| **Revenue** | | |
| Manitoba Health | **$ 15,000** | $ 15,000 |
| **Expenses** | | |
| Employee costs | **13,000** | 13,000 |
| Professional fees | **797** | 1,047 |
| Overhead | **1,380** | 1,405 |
| | **15,177** | 15,452 |
| **Deficiency of revenue over expenses for the year** | **(177)** | (452) |
| **Net assets (deficit),** beginning of year | **(872)** | (420) |
| **Net assets (deficit),** end of year | **$ (1,049)** | $ (872) |

# THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA
## Notes to Financial Statements

**For the year ended April 30, 2025**

### 1. Nature of the Program

The College of Physicians and Surgeons of Manitoba (the "Organization") through the Manitoba Physician Public Register Program (the "Program") makes available to the public the Physician Public Register information in accordance with sections 28(3), (4) and (5) of the Regulated Health Professionals Act and section 2.6(1) of the College of Physicians and Surgeons General Regulation.

This Program and its financial statements is one segment of the overall operations of the Organization.

### 2. Summary of Significant Accounting Policies

a. Basis of Presentation

The financial statements present the statement of financial position and the statement operations and changes in net assets of the Program administered by the Organization and do not represent all assets, liabilities, net assets and operations of the Organization.

b. Basis of Accounting

These financial statements have been prepared in accordance with the financial reporting provisions of section F of schedule A of the funding agreement with the Government of Manitoba as represented by Manitoba Health, Seniors and Long-Term Care (the "Agreement") dated October 3, 2024, using the recognition and measurement principles of Canadian Accounting Standards for Not-for-Profit Organizations.

c. Revenue Recognition

The Program follows the deferral method of accounting for contributions. Externally restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Until such time, externally restricted contributions are reported as deferred revenue. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

# ANNUAL GENERAL MEETING OF THE MEMBERSHIP
# JUNE 25, 2025
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** Appointment of the Auditor

## BACKGROUND:

According to the *Affairs of the College Bylaw*, the annual appointment of the auditors of CPSM is to take place at the Annual General Meeting.

BDO is in the second year of a 5-year agreement with CPSM as external auditors. BDO successfully completed the audit for this fiscal year ending April 30, 2025.

At the June 4, 2025 Finance Audit and Risk Management Committee meeting, the motion was passed to recommend at the 2025 AGM that BDO be appointed as the auditor for the 2025/26 fiscal year.

## MOTION:

**NOTICE IS HEREBY GIVEN THAT AT THE ANNUAL GENERAL MEETING OF THE MEMBERSHIP OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 25, 2025, DR. CHARLES PENNER, CHAIR OF THE FINANCE, AUDIT AND RISK MANAGEMENT COMMITTEE, WILL MOVE THAT:**

> The registrants approve BDO Canada LLP be appointed as auditors for all CPSM accounts in the forthcoming fiscal year 2025/2026 as recommended by the Finance, Audit and Risk Management Committee.

**Notice of Motion Briefing Note Prepared by: Mr. Paul Penner, Chief Financial Officer**

# ANNUAL GENERAL MEETING OF THE MEMBERSHIP
# JUNE 25, 2025
# NOTICE OF MOTION FOR APPROVAL

**SUBJECT:** Motion to approve Bylaw Amendments

## BACKGROUND:

In accordance with the *Regulated Health Professions Act*, all bylaw amendments approved by Council in the past year, must now be confirmed or varied by the members who are present and voting at this annual general meeting.

The following bylaw was amended in the past year.

*Accredited Facilities Bylaw* amendment September 25, 2024

There were 5 amendments to the *Accredited Facilities Bylaw*:

1. Section **13.3.3.vi** – tumescent liposuction.
2. Section **13.3.3.xi** – any procedure that the Program Review Committee directs.
3. Bylaw list – Intravenous ketamine administration.
4. Bylaw list – MDMA (3,4-methylenedioxymethamphetamine)-Assisted Therapy (MMDA-AT).
5. Requiring anesthesiologists working in dental clinics to report Adverse Patient Outcomes.

A tracked changed version of the amended Accredited Facilities Bylaw is attached as ***Appendix A.***

## MOTION:

**NOTICE IS HEREBY GIVEN THAT AT THE ANNUAL GENERAL MEETING OF THE MEMBERS OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 26, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT WILL MOVE THAT**:

The Membership approve the amendments listed above to the *Accredited Facilities Bylaw*.

**Notice of Motion Briefing Note prepared by: Mr. Mike Triggs, General Counsel**

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# Accredited Facilities Bylaw

**(Under Section 183 of *The Regulated Health Professions Act*)**

## The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019
**With revisions up to and including June 25, 2025**

Table of Contents

## Preamble

**Prior to making this Bylaw, the Minister must be provided with a copy of the proposed Bylaw for review and Council must review and consider any comments made, pursuant to s. 183 of the RHPA.**

# PART A – DIAGNOSTIC FACILITIES

## Article 1 – Definitions

1.1. In Part A of Bylaw:

1.1.1. "**accreditation**" means a review process conducted by CPSM to determine whether the facility being reviewed meets the standards specified by CPSM.

1.1.2. **"anatomic pathology laboratory"** means a place where human surgical tissue biopsies and specimens, cytological specimens and autopsies are examined for diagnostic purposes.

1.1.3. **"certificate of accreditation"** means a certificate issued under this Part of the Bylaw.

1.1.4. **"clinical pathology laboratory"** means a place where diagnostic testing is performed on human samples including the disciplines of chemistry, hematology, transfusion medicine, cytology, immunology, microbiology, virology, histology or pathology.

1.1.5. **"Committee"** means the Program Review Committee of CPSM.

1.1.6. **"diagnostic imaging facility"** means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound, computed tomography, magnetic resonance imaging, fluoroscopy, mammography or nuclear medicine.

1.1.7. **"facility"** means a place or a vehicle, whether privately owned or affiliated with or administered by a hospital or other health facility, which is principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, a clinical pathology laboratory, a diagnostic imaging facility, or a patient service centre. A clinical pathology laboratory facility may be comprised of a primary location, which is its laboratory, and one or more patient service centres.

1.1.8. **"Facility Director"** means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term "medical director" used in section 183(3) of the RHPA.

1.1.9. **"patient service centre"** means a location for the collection and/or testing of specimens of blood and of body fluids for the purpose of testing in an accredited laboratory.

1.1.10. **"physician office laboratory"** means a physician's office where specimens are collected and tested by the physician or a laboratory technician/assistant qualified by training from an accredited medical laboratory technician/assistant training program and is certified or eligible for certification with the Canadian Society of Medical Laboratory Science for the diagnosis of the physician's own patients.

1.1.11. **"Standards"** means the Standards approved by the Committee for facilities.

1.1.12. **"vehicle"** means a device in, upon or by which diagnostic equipment is transported upon a roadway and which is:

1.1.12.i. used primarily for the purpose of offering diagnostic services; and

1.1.12.ii. has the approval of the Government of Manitoba to offer diagnostic services in Manitoba but does not include an emergency vehicle as defined in *The Highway Traffic Act*.

1.2. In this Bylaw, words and phrases defined in *The RHPA* have the same meaning as in the *RHPA*.

## Article 2 – Application of this Part

Part A of this Bylaw applies as follows:

2.1. Pursuant to *The Regulated Health Professions Act (RHPA),* ss 183(1)[1], to all diagnostic facilities in Manitoba which are principally equipped to perform a procedure normally performed in an anatomic pathology laboratory, clinical pathology laboratory, diagnostic imaging facility, and patient service centre, in which services are performed by registrants of CPSM, other than those under the jurisdiction of the provincial or municipal governments and those designated as hospitals under *The Health Services Insurance Act,* and a facility or class of facilities exempted by Regulation from the application of s.183(1) of the *RHPA*.

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than

(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;

(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and

(c) a facility or class of facility exempted by regulation from the application of this section.

2.2. Pursuant to *s.183(15)*[2] *of the RHPA* and pursuant to the Service Purchase Agreement made between the College of Physicians and Surgeons of Manitoba and the Government of Manitoba governing diagnostic facilities, to those diagnostic facilities falling within the jurisdiction of the Government of Manitoba as specified in the Service Purchase Agreement.

2.3. Pursuant to s.12.3(1) (d) of the *CPSM General Regulation* this does not apply to a facility operated by the Canadian Blood Services, CancerCare Manitoba, St. Amant Inc., or Mount Carmel Clinic unless it is part of the Service Purchase Agreement referred to above.

## Article 3 – Facility Accreditation

3.1. A facility is required to obtain accreditation before it offers any services to the public.

3.2. Accreditation of a facility must be:
- 3.2.1. except in the case of a vehicle, for a specific address or addresses.
- 3.2.2. for the fixed period of time determined by the Committee, to a maximum of 5 years.
- 3.2.3. for the procedures specified with the certificate of accreditation.

3.3. In the case of a vehicle, the facility must provide a current mailing address for the owner and the operator of the service.

3.4. Prerequisites to full accreditation of a facility pursuant to this By-law are:
- 3.4.1. compliance with the relevant standards; and
- 3.4.2. appointment of a Facility Director acceptable to the Committee.

3.5. The Committee must establish and make available on request:
- 3.5.1. Operational/technical standards for each type of facility.
- 3.5.2. the accreditation process for each type of facility.
- 3.5.3. the Committee's policies governing the accreditation process for each type of facility.

3.6. Applications for accreditation of a facility must be made to the Committee by the Facility Director, on the forms prescribed by the Committee, and must contain the information required by the Committee.

[2] 183(15) The council may enter into agreements with the government, the government of Canada or a municipal government to make this section applicable to any facility or any part of a facility that falls within that government's jurisdiction.

**Accreditation Process**

3.7. The accreditation process will include:
- 3.7.1 completion of a pre-inspection questionnaire by the Facility Director;
- 3.7.2 an inspection by one or more persons, with knowledge in the facility's work, designated by the Committee;
- 3.7.3 review of the facility's compliance with standards;

3.8. On completion of the accreditation process, the Committee may:
- 3.8.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all the requirements of Part A of this Bylaw and there are no identified deficiencies;
- 3.8.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;
- 3.8.3 deny accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or
- 3.8.4 withdraw any existing accreditation.

3.9. Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

**Full Accreditation**

3.10. Where a facility fully complies with the relevant standards, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

**Accreditation Not Granted**

3.11. Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

**Conditional Accreditation**

3.12. Where a facility does not fully comply with the relevant standards, but the Committee is of the opinion that it is in the public interest to permit the facility to operate while it corrects specified deficiencies, the Committee may grant conditional accreditation.

3.13. Where conditional accreditation is granted, the Committee must:
- 3.13.1. provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

3.13.2. state in its decision a fixed deadline for the facility to comply with all relevant standards and for the Facility Director to provide written confirmation of compliance to the Committee.

3.13.3. state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

3.14. The Committee may extend the deadline for compliance with standards if, in its sole discretion, the Committee deems it appropriate to do so.

3.15. Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:

3.15.1. Extend conditional accreditation

3.15.2. direct an inspection.

3.15.3. withdraw the conditional accreditation and if the facility is publicly owned, report the matter to government with the request that the government require the facility to cease operation.

3.16. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit registrants from using the facility.

**Accreditation Status Review**

3.17. Accreditation status may be reviewed at the discretion of the Committee.

**Temporary Accreditation**

3.18. Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

**Role of Facility Director During Accreditation**

3.19. Facility Director and personnel who are subject to the accreditation process must cooperate fully, which includes but is not limited to:

3.19.1. permitting inspectors to enter the facility and inspect the premises and all diagnostic equipment located therein.

3.19.2. permitting inspectors to inspect all records pertaining to the provision of services and providing copies of the same if so requested.

3.19.3. providing requested samples or copies of any material, specimen, radiological image or product originating from the diagnostic service.

3.19.4. answering questions posed by the inspectors as to the procedures or standards of performance relating to examinations/procedures performed.

## Article 4 – Maintenance of Accreditation

4.1. In order to maintain accreditation, a facility must:

4.1.1. comply with the relevant standards.

4.1.2. perform only the procedures permitted pursuant to the facility's certificate of accreditation.

4.1.3. at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect.

4.1.4. cooperate with and participate in the inspection process approved by the Committee for its type of facility.

4.2. During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:

4.2.1. a facility may not meet the relevant standards and

4.2.2. an inspection would be in the public's best interest.

## Article 5 – Renewal of Accreditation

5.1. In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

## Article 6 – Variance or Withdrawal of Accreditation

6.1 A facility may apply at any time to vary its accreditation.

6.2 If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and if the facility is publicly owned, report the matter to government with the recommendation that the government require the facility to cease operation. If the Committee is of the opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit registrants from using the facility.

6.3 Where a facility is no longer providing patient services, the Committee may withdraw the facility's accreditation

6.4 Council may withdraw accreditation in accordance with the RHPA

## Article 7 – Facility Director

7.1. A facility must have a Facility Director.

7.2. A Facility Director must be a physician whose credentials are acceptable to the Committee.

7.3. The Committee must establish and make available on request the qualifications for Facility Directors in each type of facility.

7.4. The Facility Director is responsible for granting privileges to any physician who wishes to work for the facility and notifying the Committee of the physicians who are granted privileges. Before granting privileges to any physician a Facility Director must:

- 7.4.1. define in writing the qualifications and competencies required in order to obtain privileges in each field of practice.
- 7.4.2. obtain written confirmation that the applicant is registered and licensed to practice medicine in Manitoba.
- 7.4.3. obtain full particulars of the applicant's education, training, competencies and experience.
- 7.4.4. take reasonable steps to ensure that the applicant has the education, training competencies and experience required, and that the applicant is otherwise a suitable candidate for privileges.

7.5. Within one year of first granting privileges to a physician, the Facility Director must review that physician's privileges. Thereafter, privileges must be reviewed by the Facility Director at least every two years.

7.6. Before granting renewal of privileges or extending the existing privileges of any physician, the Facility Director must take reasonable steps to ensure that the physician has the education, training, competencies and experience required for each field of practice for which he or she is seeking privileges within the facility.

7.7. The Facility Director must have effective control of and be responsible for the safe operation and administration of the facility, the supervision of all professional, technical and administrative activities of the facility, and for compliance with this Bylaw and with the relevant standards established by the Committee.

7.8. Without limiting the generality of the foregoing, the Facility Director must:

- 7.8.1. have access to all records and documents relating to the operation of the facility and the procedures performed therein.
- 7.8.2. communicate with any facility under his/her direction a minimum of once per year.
- 7.8.3. ensure that quality management system requirements and improvement programs are in place.
- 7.8.4. ensure that the facility has current up to date policies and manuals as required by the standards for that facility.

7.8.5. ensure that complete and accurate patient records and documentation relating to the operation of the facility and procedures performed are kept.

7.8.6. ensure that no procedure is carried out in the facility unless it is permitted by the certificate of accreditation.

7.8.7. ensure that technologists have the qualifications as provided by training from an accredited:

7.8.7.i. medical laboratory training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.7.ii. medical radiology technology training program and are certified or eligible for certification with the Canadian Association of Medical Radiology Technologists.

7.8.8. ensure that medical laboratory technologists who are required to perform x-ray examinations and medical radiology technologists who are required to perform laboratory testing have graduated from a cross-training program.

7.8.9. ensure that laboratory technicians/assistants have the qualifications as provided by training from an accredited medical laboratory technician/assistant training program and are certified or eligible for certification with the Canadian Society of Medical Laboratory Science.

7.8.10. ensure that persons who provide services to the facility maintain competence to perform the procedures for which the facility is accredited.

7.8.11. ensure that work referred out of the facility is performed by persons with appropriate qualifications and competence to perform the work.

7.8.12. promptly notify CPSM of any change in the ownership or directorship of the facility.

7.8.13. promptly notify CPSM if the facility is no longer providing patient services.

7.8.14. where applicable, be available for consultation with referring physicians.

7.8.15. promptly notify the Committee if there is a major change in the following:

7.8.15.i. equipment.

7.8.15.ii. the accredited list of diagnostic imaging examinations, laboratory or transfusion medicine tests, or blood and blood products dispensed.

7.8.16. ensure that the duties and responsibilities of all personnel are written and understood;

7.8.17. ensure adequate quality assurance and improvement programs are in place

7.9. The Facility Director must submit to CPSM such information as required by the Committee.

## Article 8 – Appeal

8.1. The facility or a registrant may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.

## Article 9 – Fees

9.1. A privately-owned facility shall pay all expenses, charges and fees incurred by CPSM in respect of the accreditation or inspection of the facility and the administration of Part A of this Bylaw.

## Article 10 – Physician Office Laboratory

10.1. Physicians must not operate a physician office laboratory without first obtaining the written approval of CPSM.

10.2. The Committee may direct the inspection of any facility where physician office laboratory procedures are performed.

## Article 11 – Transition

11.1. A facility that holds accreditation at the time this Bylaw comes into force continues to hold that accreditation status under this Bylaw in accordance with the terms of that accreditation.

11.2. A facility which has not undergone the accreditation process will be notified in writing by CPSM that it is exempt from the requirement of accreditation set forth in this Bylaw until the inspection process for that facility is complete and a report is issued, but the facility must cooperate with CPSM for the timely completion of its accreditation process in accordance with this Bylaw.

11.3. A physician who holds a Facility Directorship at the time this Bylaw comes into force continues to hold that status under this Bylaw.

# PART B – NON-HOSPITAL MEDICAL OR SURGICAL FACILITIES

## Article 12 – Definitions

12.1. In Part B of this Bylaw:

**“accreditation”** means a review process conducted by CPSM to determine whether the facility being reviewed meets the requirements specified by CPSM.

**"certificate of accreditation"** means a certificate issued under this Part of the Bylaw.

**"Committee"** means the Program Review Committee of CPSM.

**“direct or indirect financial interest”** means any interest owned by a registrant, by individuals connected by blood relationship, marriage or adoption to a registrant, by any corporation, proprietorship, partnership, society, business, association, joint venture, group or syndicate in which a registrant or any individual connected by blood relationship, marriage or adoption to a registrant have any interest.

**"facility"** means a non-hospital medical or surgical facility for the purposes of Part B of this Bylaw.

**“general anaesthesia”** means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to maintain an airway independently, or to respond purposefully to physical stimulation or verbal command, produced by pharmacologic or non-pharmacologic methods, alone or in combination.

**“hospital”** means a hospital under *The Hospitals Act* or the *Regional Health Authorities (Health System Governance and Accountability) Act* when proclaimed with an operational Emergency or Urgent Care Department.

**"medical director"** means a physician appointed as director of a facility in accordance with this Part of the Bylaw and whose credentials are acceptable to the Committee and is synonymous with the term “medical director” used in section 183(3) of the RHPA.

“**oral sedation**” means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents and with is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states.

**"privileges"** means the authority to admit and treat patients at a facility.

**“procedural sedation”** means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees

of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

i. includes, but is not limited to, the use of any IV or intra-muscular agent for this purpose; and
ii. requires the monitoring of vital signs,

but does not include the use of oral pre-medication alone or in combination with local anaesthesia. No distinction is made between light and deep procedural sedation for credentialing or monitoring purposes.

**"procedure"** means the diagnostic and treatment procedures, both medical and surgical, as approved by the Committee to be carried out in a facility.

## Article 13 – Application of this Part – Procedures Requiring Accreditation

13.1. Part B of this Bylaw applies to all non-hospital medical or surgical facilities, subject to section 183 of the RHPA, and not included in Part A of this Bylaw. All non-hospital medical or surgical facilities in which procedures that have a sufficient risk of potential harm to a patient must apply for, obtain, and maintain accreditation from CPSM prior to providing any such diagnostic or treatment services or procedures.

13.2. The criteria for assessing sufficient risk of potential harm to a patient include:
- 13.2.1. Level of anaesthesia and/or sedation
- 13.2.2. Need for medical device reprocessing (infection risk)
- 13.2.3. Complexity of procedure and risk of complications

13.3. The following procedures have a sufficient risk of potential harm to the patient to require accreditation:
- 13.3.1. Any procedure that is carried out or should be carried out in accordance with generally accepted standards of care with the concurrent use of procedural or oral sedation including for patient comfort (pain and/or anxiety); See definitions of procedural and oral sedation in Article 12.
- 13.3.2. Any procedure that requires general anaesthesia, See definition of general anaesthesia; or
- 13.3.3. Procedures involving:
  - 13.3.3.i. deep, major, and complicated procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care. These procedures may include:
    - 13.3.3.i.a. resection of a deep, major or complicated lesion;
    - 13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal

organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;

13.3.3.ii. flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;

13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;

13.3.3.iv. the following Ophthalmological Procedures:

13.3.3.iv.a. cataract surgical procedures

13.3.3.iv.b. corneal laser procedures

13.3.3.iv.c. retinal procedures limited to scleral buckling and vitrectomies

13.3.3.iv.d. Lasik therapeutic procedures

13.3.3.v. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;

13.3.3.vi. ~~any tumescent~~ liposuction procedure~~s involving the administration of dilute local anaesthesia~~;

13.3.3.vii. hair transplantation;

13.3.3.viii. venous sclerotherapy;

13.3.3.ix. hyperbaric oxygen therapy;

13.3.3.x. hemodialysis;

13.3.3.xi. intravenous Ketamine administration;

~~13.3.3.x.~~13.3.3.xii. MDMA (3,4-methylenedioxymethamphetamine); or

~~13.3.3.xi. any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility, in order to meet the minimum acceptable standard of care for that procedure. (see list at end of bylaw)~~

13.4. CPSM registrants providing anaesthesiology services for dental procedures undertaken by members of the Manitoba Dental Association in dental surgery clinics, must comply with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association.

~~13.3.4.~~13.4.1. In addition to complying with the Pharmacologic Behaviour Management Bylaw of the Manitoba Dental Association, CPSM registrants providing these services must notify the Assistant Registrar within one working day of becoming aware of any major adverse patient outcome resulting from the anesthesiology services provided in the dental surgery clinic.

~~13.4.~~13.5. This Part of the Bylaw does not apply to any hospital or health care facility operated by a health authority or the Governments of Canada, Manitoba, or any municipality.

## Article 14 – Registrants Must not Work in Non-Accredited Facilities

14.1. A registrant must not perform or cause to be performed any procedure in a facility that requires accreditation under this Part, but is not accredited, in accordance with s. 183(14) of the RHPA and in accordance with the transition provisions in Article 29.

14.2. A facility is required to obtain accreditation before it offers any services to the public.

## Article 15 – Facility Accreditation

15.1 The medical director of a facility seeking accreditation must apply on the form prescribed by the Committee, specifying the procedures for which accreditation is sought.

15.2 The medical director must agree to pay the fee charged for the inspection and accreditation process even if the accreditation is not completed or granted.

**Accreditation Process**

15.3 The accreditation process will include:

- 15.3.1 completion of a pre-inspection questionnaire by the medical director;
- 15.3.2 an inspection by one or more registrants, with expertise in the appropriate area of medical practice, designated by the Committee;
- 15.3.3 review of the facility's compliance with requirements including CPSM and medical or other standards; and
- 15.3.4 CPSM providing the Minister with a copy of each application and report as required by section 183(17) of the RHPA.

15.4 On completion of the accreditation process, the Committee may:

- 15.4.1 grant full accreditation and issue a certificate of accreditation to a facility if the Committee is satisfied that the facility has met all of the requirements of Part B of this Bylaw and there are no identified deficiencies;
- 15.4.2 grant conditional accreditation to a facility with identified deficiencies and specifying the date it will expire if the identified deficiencies are not corrected;
- 15.4.3 not grant accreditation pending correction of identified deficiencies in accordance with s. 183(7) of the RHPA; or
- 15.4.4 withdraw any existing accreditation.

15.5 Where an inspection is conducted as part of the accreditation process, and deficiencies are observed, the Committee must issue a report of the inspection and must provide a copy of the report to the applicant.

**Full Accreditation**

15.6 Where a facility fully complies with the relevant requirements, the Committee will grant full accreditation and will specify with the certificate of accreditation the procedures for which the facility is accredited.

**Accreditation Not Granted**

15.7 Where accreditation is not granted, the Committee must provide written notice of its decision and the reasons therefor and information on the right of appeal to the Executive Committee.

**Conditional Accreditation**

15.8 In circumstances where a facility does not comply fully with all requirements for accreditation, and if the Committee deems it adequate for patient safety, conditional approval may be granted for the operation of a facility pending the completion of the accreditation process or while it corrects specified deficiencies.

15.9 Where conditional accreditation is granted, the Committee must:

15.9.1 provide written notice of its decision and the reasons therefor and the information on the right of appeal to the Executive Committee.

15.9.2 state in its decision a fixed deadline for the facility to comply with all relevant standards and for the medical director to provide written confirmation of compliance to the Committee.

15.9.3 state in its decision whether a follow-up inspection must occur before full accreditation may be granted.

15.10 Where conditional accreditation is granted, the medical director must provide a written response to each deficiency within the time specified by the Committee, and a follow-up inspection may occur, if the Committee so directs. Full accreditation will only be granted when identified deficiencies have been corrected to the satisfaction of the Committee.

15.11 The Committee may extend the deadline for compliance with requirements if, in its sole discretion, the Committee deems it appropriate to do so.

15.12 Where a facility with conditional accreditation has not complied with the conditions of accreditation within the time frame fixed by the Committee, the Committee may:

15.12.1 extend conditional accreditation;

15.12.2 direct an inspection;

15.12.3 withdraw the conditional accreditations.

**Temporary Accreditation**

15.13 Temporary accreditation may be granted for the continued operation of a facility, if the facility is already accredited, in circumstances which the Committee deems appropriate, pending the completion of the re-accreditation process.

**Term of Accreditation and Renewal**

15.14 Accreditation of a facility must be for the fixed period of time determined by the Committee, to a maximum of five years.

15.15 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation. The re-accreditation process will follow the same procedure as required for accreditation. Where an application to renew is pending, the Committee may continue the facility's accreditation until a decision is made on the renewal application.

## Article 16 – Maintenance of Accreditation

16.1 In order to maintain accreditation, a facility must:

- 16.1.1 comply with the relevant requirements;
- 16.1.2 perform only the procedures permitted pursuant to the facility's certificate of accreditation;
- 16.1.3 at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect; and
- 16.1.4 cooperate with and participate in the inspection process approved by the Committee for its type of facility.

16.2 During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:

- 16.2.1 a facility may not meet the requirements, standards of practice, or other standards for public safety and.
- 16.2.2 an inspection would be in the public's best interest.

## Article 17 – Renewal of Accreditation

17.1 In order to renew accreditation, a facility must re-apply for accreditation at least six months prior to the expiration date of the existing accreditation.

## Article 18 – Variance or Withdrawal of Accreditation

18.1. A facility may apply at any time to vary its accreditation.

18.2. If the Committee is of the opinion that the facility may be unsafe, the Committee must review the facility's accreditation and may take such steps with respect to the facility's accreditation as the Committee deems appropriate in the circumstances, including withdrawing accreditation and ordering it to cease operation. If the Committee is of the

opinion that the facility is unsafe, it must request the Registrar to notify the public of the deficiencies and prohibit registrants from using the facility.

18.3. Where a facility is no longer providing patient services, the Committee may withdraw the facility's accreditation.

18.4. Council may withdraw accreditation in accordance with the RHPA.

## Article 19 – Approved Procedures

19.1. Each certificate of accreditation must include a schedule listing the procedures which have been approved for the facility, and the names of the registrants who have been given privileges to perform the procedures at the facility.

19.2. The schedule of procedures may be amended from time to time upon the application of the facility and the approval of the Committee.

19.3. Only those procedures which are approved by the Committee and set out in the schedule to the facility's certificate of accreditation may be performed in the facility.

19.4. Where a facility is no longer being used for the procedures set out in Article 13, the Medical Director must inform the Assistant Registrar. The Committee may withdraw the facility's certificate of accreditation.

## Article 20 – Health Authority Agreement

20.1. Every facility must have a written agreement with a health authority pursuant to which the health authority agrees to provide emergency treatment if a patient has to be transferred from the facility.

## Article 21 – Privileges

21.1. A registrant must have privileges at an accredited facility prior to performing any of the services and procedures listed in Part B;

21.2. The Medical Director must only grant and renew privileges for a registrant to perform procedures in an accredited facility if the Medical Director is satisfied that:

21.2.1. the applicant is a suitable and competent candidate

21.2.2. the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant and

21.2.3. those privileges are the same as granted by Shared Health or a Regional Health Authority or are recommended through the Shared Health credentialing process and those privileges are and remain in good standing.

21.3. Where the registrant does not have Shared Health or Regional Health Authority privileges the Medical Director must only provide privileges for a specific facility if the Committee has already granted privileges under the following process:

21.3.1. utilize the established Shared Health credentialing process to assess applicants using established specialty groups;

21.3.2. implement a non-refundable assessment fee paid to Shared Health or the Regional Health Authority payable by the registrant seeking credentials for the credentialing process;

21.3.3. seek and obtain an assessment from Shared Health regarding the granting of privileges; and then

21.3.4. the Committee shall decide whether to grant privileges.

21.4. Within 15 calendar days of granting or renewing privileges the Medical Director must provide the Assistant Registrar with the particulars of the privileges granted in the facility.

21.5. Any registrant who performs services and procedures without obtaining privileges in the facility and any Medical Director who permits a registrant to perform services and procedures without privileges in the facility may be found guilty of professional misconduct.

## Article 22 – Standard of Care

22.1. An accredited facility and those registrants performing procedures must meet appropriate standards for the quality and safety of those treatments and procedures performed in that facility. To receive and maintain accredited status, a facility must:

22.1.1. demonstrate compliance with appropriate standards for quality and safety of treatments and procedures performed;

22.1.2. provide patient care in a manner consistent with good medical care as defined in the CPSM Standards of Practice Regulation and elaborated on in the Standards of Practice, Practice Directions, and Code of Ethics and Professionalism; and

22.1.3. engage in ongoing processes of self-review and quality improvement.

## Article 23 – Patient Care

23.1. Anaesthetic Care

23.1.1. All patients proposed to undergo anaesthesia in a facility must be assigned an American Society of Anaesthesia risk score and only patients with ASA I, II and III Risk scores may have a procedure performed unless otherwise indicated in the accreditation approval.

23.1.2. General anaesthesia must not be given to infants under the age of twenty-four months.

23.1.3. A patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of an adult.

23.1.4. Procedural sedation must be administered by or under the direct supervision of a registrant with appropriate training acceptable to CPSM to provide procedural sedation.

23.1.5. A patient who receives procedural sedation must be attended by a registered nurse or a registrant who is not assisting in the surgical procedure and who is trained to monitor patients under procedural sedation.

23.1.6. There must be at least two personnel who are certified in basic cardiopulmonary resuscitation within the facility while patients are receiving care.

23.1.7. All equipment for the administration of anaesthetics must be readily available, clean and properly maintained.

23.2. A registrant who has been granted privileges must:

23.2.1. be in the room at all material times during the performance of a procedure in the facility.

23.2.2. ensure that following any procedure, patients receive an adequate recovery period under supervision before leaving the facility.

23.2.3. be responsible for the post-operative care of the patient within the facility.

23.2.4. ensure qualified support staff are on duty during and after a procedure in the facility.

23.2.5. maintain accurate information concerning the medical condition of patients in a clinical record which meets the expected standards of medical record-keeping, including documentation related to the informed consent of the patient for the procedure(s) performed in a facility.

23.2.6. perform procedures in a facility only if the facility is adequately equipped and has maintained operating and post-operative rooms and all equipment is safe, well maintained and compliant with applicable federal, provincial, and municipal legislation.

23.3. A registrant shall not perform a procedure in an accredited facility unless the procedure is one that should safely allow the discharge of a patient from medical care in the facility within 23 hours of the day cycle (no overnight).

## Article 24 – Infection Control

24.1 A facility must:

24.1.1 use sterilization techniques,

24.1.2 store medical and dental supplies, and

24.1.3 use waste handling and disposal procedures

consistent with the standards applicable to hospitals.

24.2 A facility must comply with all guidelines CPSM may require the facility to comply with to meet best practices on infection control practices in a facility setting, including the Ontario Public Health Infection Prevention and Control for Clinical Office Practice.

## Article 25 – Medical Director

25.1 The facility shall appoint a medical director, who is a registrant acceptable to the Committee, and who must:

25.1.1 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

25.1.2 be responsible for the administration of the facility; and

25.1.3 provide required reporting to CPSM.

25.2 In enforcing the standards of care in the facility which includes the safe and effective care of patients, the medical director must ensure that:

25.2.1 procedures and equipment are appropriate and safe;

25.2.2 procedures are performed in accordance with current good medical care and practice;

25.2.3 sufficient numbers of appropriately trained personnel are present during procedures;

25.2.4 procedures approved by the Committee as set out in the certificate of accreditation are only performed at the facility by registrants with privileges;

25.2.5 persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;

25.2.6 registrants with privileges have current basic life support skills and other skills appropriate to the clinical settings (such as advanced cardiac support, pediatric advanced life support, and airway management skills);

25.2.7 all direct patient care personnel have life support skills and there must be two such qualified personnel present at any time patients are receiving care;

25.2.8 adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place.

25.3 In being responsible for the administration of the facility, the medical director must:

25.3.1 have access to all records and documents relating to the operation of the facility and the procedures performed therein;

25.3.2 develop appropriate and up-to-date policy and procedure manuals, including acceptable staff health policies;

25.3.3 ensure the duties and responsibilities of all personnel are written and understood;

25.3.4 ensure complete and accurate confidential patient records and documentation relating to the operation of the facility and procedures performed are kept current and up to date;

25.3.5 ensure the requirements for granting privileges are met with necessary approvals and complete records kept of all registrants who obtain privileges at the facility, including their applications;

25.3.6 ensure documentation, fees and a complete reporting of all required information to CPSM is submitted when and as required;

25.3.7 meet annually with each registrant who has privileges to review those privileges and document the review; and

25.3.8 attend at the facility at least one day per month or more if prescribed by the Committee to inspect the facility, and meet with other staff to review operations, the facility, standards, and quality assurance;

25.4 In providing required reporting to CPSM, the medical director must:

25.4.1 Ensure that the Assistant Registrar is notified within one working day of becoming aware of any of the following circumstances and provide a report within two weeks of any of the following:

25.4.1.i death that occurs within 10 days of the procedure;

25.4.1.ii transfers from the facility to a hospital regardless of whether or not the patient was admitted;

25.4.1.iii unexpected admission to hospital within 10 days of a procedure performed;

25.4.1.iv clusters of infections among patients treated in the facility; or

25.4.1.v procedure performed on wrong patient, side, or site or wrong procedure; or

25.4.1.vi any other major adverse patient outcome.

25.4.2 notify the Assistant Registrar of any change in ownership of the facility within one month;

25.4.3 promptly notify the Assistant Registrar if the facility is no longer providing patient services within one month;

25.4.4 promptly notify the Assistant Registrar if there is a major change in equipment or renovations to the facility or the accredited list of procedures within ten days; and

25.4.5 advise the Assistant Registrar of resignation, revocation, suspension, or restriction of privileges of staff immediately.

## Article 26 – Audit and Quality Control

26.1 All certificates of accreditation are subject to the following conditions:

26.1.1 all procedures and all clinical records must comply with the requirements of standards of care set by CPSM.

26.1.2 quality assurance and improvement programs are in place sufficient to demonstrate that standards of care set by CPSM and required for good medical care are met in the facility.

## Article 27 – Annual Report

27.1. The medical director must review the facility's quality assurance and improvement programs at least annually.

27.2. Within 30 days of each calendar year end, the medical director must forward an annual report in the prescribed form to the Assistant Registrar outlining:

27.2.1 the exact number and types of procedures performed in the facility;

27.2.2 the exact number and type of adverse outcomes and events, including infections and complications, arising from procedures done in the facility;

27.2.3 exact number of events such as needlestick, incomplete sterilization, breaks in technique, medication errors, each of which must be investigated and documented;

27.2.4 assurance that quality assurance and quality improvement program initiatives in the facility sufficient to demonstrate the standards of care set by CPSM and required for good medical care;

27.2.5 the number of transfers to hospital from the facility

27.2.6 list of registrants with privileges and health care staff

27.2.7 List of registrants whose privileges were not renewed, or suspended, or revoked with details;

27.3. Included with the annual report, the medical director must review, sign, and return to the Assistant Registrar an annual declaration in a form prescribed by the Committee confirming that they are aware of their responsibilities as set out in law, this Bylaw, Standards of Practice, and Practice Directions.

## Article 28 – Inspections and Audits

28.1. At any time and without notice, a facility is subject to inspection and audits by registrants or other persons with expertise (the latter designated by the Assistant Registrar) to conduct inspections and audits, including, but not limited to if there is:

28.1.1. a change in or addition to procedures offered at the facility;

28.1.2. renovations in the facility;

28.1.3. an adverse patient outcome;

28.1.4. a possible failure to comply with this Bylaw or the approval accreditation;
28.1.5. a possible failure to meet appropriate standards;
28.1.6. a possible risk to patient care and safety.

28.2. The facility will be required to pay the costs of any such inspection/audit and any required follow-up expenses.

28.3. If access to the facility for any inspection is refused, the Committee may take such action it deems necessary including, suspending, revoking or amending the facility's certificate of accreditation.

28.4. The Committee may appoint an investigator with powers under s. 183(6) of the RHPA.

## Article 29 – Appeal

29.1 The facility or a registrant may appeal any decision of the Committee to the Executive Committee pursuant to sections 183 and 38 of the RHPA by filing a written notice of appeal with the Registrar within thirty calendar days of being informed of the decision. The notice of appeal must specify the reasons for the appeal.

## Article 30 – Administration Fees for Facilities

30.1 The facility shall pay all expenses, charges and fees incurred by CPSM in respect of the accreditation or inspection of the facility and the administration of Part B of this Bylaw.

## Article 31 – Transition

31.1 All accreditations and approvals of facilities, procedures, medical directors, conditions, and privileges granted at the time this Bylaw comes into force continues to be valid.

31.2 To permit the orderly accreditation of new facilities under Article 14 effective the date of the Annual General Meeting, June 9, 2021, registrants must not perform these procedures at a facility unless the facility:
31.2.1 has applied for accreditation by December 1, 2021,
31.2.2 has been granted at least conditional or full accreditation by December 1, 2022,
31.2.3 is actively working on obtaining full accreditation as determined by the Committee, and
31.2.4 is seeking to comply with all requirements of this Part of the Bylaw as if it were a fully accredited facility.

31.3 The Committee may determine whether the facility is compliant with the provisions in 31.2.3 and 31.2.4.

# ANNUAL GENERAL MEETING OF THE MEMBERSHIP
# JUNE 25, 2025
## FOR INFORMATION BRIEFING NOTE

**SUBJECT:** CPSM 2025 Election Results

**BACKGROUND:**

The *Affairs of the College Bylaw* establishes the election process. This year the Notice of Election, including a voters list, nomination form and procedures for nominating was sent to all eligible registrants for the East Electoral District (By-election) and the Regulated Associate Registrants on March 18, 2025. Nominations were due on or before noon on April 8, 2025.

Results are as follows:

**East Electoral District (By-election)**

No nominations were received. Pursuant to *Section 24* of the *Affairs of the College Bylaw*, the Executive Committee appointed Dr. Ganesan Abbu as Councillor for the remainder of the term for the East Electoral District.

**Regulated Associate Registrant Election**

At the close of nominations at noon on April 8th there were three nominations received for one Regulated Associate Registrant seat, so an election commenced with voting ending at noon on May 6, 2025. Dr. Wendy (Yushi) MacMillan-Wang has been re-elected as the Regulated Associate Registrant member on Council.