**Application for PART I**

**American Board of Clinical Neurophysiology Certification Examination**

**MARKING INSTRUCTIONS:** This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided.

### Candidate Information

<table>
<thead>
<tr>
<th>Last Name and Suffix (Jr., Sr., etc.)</th>
<th>Middle Initial</th>
<th>First Name</th>
<th>Number and Street</th>
<th>Apartment Number</th>
<th>City</th>
<th>State/Province</th>
<th>Zip/Postal Code</th>
<th>Daytime Phone</th>
<th>Evening Phone</th>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Background and Training

*Darken only one choice for each question unless otherwise directed.*

#### A. HOW LONG WAS YOUR SUBSPECIALTY FELLOWSHIP?

- [ ] 12 months
- [ ] 13 to 24 months
- [ ] Over 24 months

#### B. WHAT PERCENT OF YOUR TIME DID YOU DEVOTE TO EEG, EXCLUSIVE OF EPILEPSY MONITORING AND INTRAOPERATIVE MONITORING?

- [ ] None
- [ ] 11 to 20%
- [ ] 21 to 30%
- [ ] 31 to 50%
- [ ] Over 50%

#### C. WHAT PERCENT OF YOUR TIME DID YOU DEVOTE TO EVOLED POTENTIALS, EXCLUSIVE OF INTRAOPERATIVE MONITORING?

- [ ] None
- [ ] 11 to 20%
- [ ] 21 to 30%
- [ ] 31 to 50%
- [ ] Over 50%

#### D. WHAT PERCENT OF YOUR TIME DID YOU DEVOTE TO INTRAOPERATIVE MONITORING?

- [ ] None
- [ ] 11 to 20%
- [ ] 21 to 30%
- [ ] 31 to 50%
- [ ] Over 50%

#### E. WHAT PERCENT OF YOUR TIME DID YOU DEVOTE TO EPILEPSY MONITORING?

- [ ] None
- [ ] 11 to 20%
- [ ] 21 to 30%
- [ ] 31 to 50%
- [ ] Over 50%

#### F. WHAT PERCENT OF YOUR TIME DID YOU DEVOTE TO SLEEP MONITORING?

- [ ] None
- [ ] 11 to 20%
- [ ] 21 to 30%
- [ ] 31 to 50%
- [ ] Over 50%

### G. WHAT PERCENT OF YOUR TIME DID YOU DEVOTE TO OTHER FORMS OF PATIENT CARE?

- [ ] None
- [ ] 11 to 20%
- [ ] 21 to 30%
- [ ] 31 to 50%
- [ ] Over 50%

### H. WHAT OTHER BOARD CERTIFICATION DO YOU HAVE? (Darken all that apply.)

- [ ] Neurology
- [ ] Neurology with special competence in child neurology
- [ ] Psychiatry
- [ ] Neurosurgery
- [ ] ABPN Subspecialty in CNP
- [ ] Sleep Medicine
- [ ] Stroke
- [ ] Electrodiagnostic Medicine
- [ ] I do not have any of the above board certifications

### OPTIONAL INFORMATION

*Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your test results.*

**Race:**

- [ ] African American
- [ ] Hispanic
- [ ] White
- [ ] Asian
- [ ] Native American
- [ ] No Response

**Age Range:**

- [ ] Under 25
- [ ] 25 to 29
- [ ] 30 to 39
- [ ] 40 to 49
- [ ] 50 to 59
- [ ] 60+

**Gender:**

- [ ] Male
- [ ] Female

---

**Candidate Signature**

I certify that the information given in this Testing Center Application is accurate, correct, and complete.

**CANDIDATE SIGNATURE:** ___________________________ **DATE:** ____________