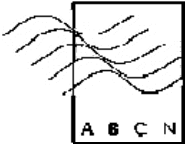


American Board of Clinical Neurophysiology

Verification of CLINICAL NEUROPHYSIOLOGY Training



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Candidate's Name: _____

Candidates' Address: _____

Location of formal clinical neurophysiology training

Dates and Duration of training

Duration Full Time Training _____ State Date _____ End Date _____

Duration Part Time Training _____ State Date _____ End Date _____

Did candidate complete training satisfactorily? Yes No

Is this candidate capable of appropriate, independent interpretation of EEGs/EPs and do you recommend this candidate for examination? Yes No

Other comments: _____

Name of training director: _____

Signature of training director: _____

Year certified by ABCN (if applicable): _____

Today's Date: _____

Please return to the ABCN Executive Office