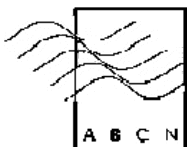


**American Board of Clinical Neurophysiology**  
**Verification of RESIDENCY Training**



ABCN Executive Office  
2509 W. Iles Ave., Ste 102  
Springfield, IL 62704  
Phone 217-726-7980  
Fax 217-726-7989

Candidate's Name: \_\_\_\_\_

Candidate's Address: \_\_\_\_\_

\_\_\_\_\_

Location of Residency Training Program

\_\_\_\_\_

\_\_\_\_\_

Dates and Duration of training: \_\_\_\_\_

**Is the training program ACGME or RCPSC Approved?**    Yes     No

**Did candidate complete training satisfactorily?**    Yes     No

**Do you recommend this candidate for examination?**    Yes     No

Other comments: \_\_\_\_\_  
\_\_\_\_\_

Name of training director: \_\_\_\_\_

Signature of training director: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please return to the ABCN Executive Office