Application for Certification Examination in Neurophysiologic Monitoring, Part I - Written



 Please read the Application Instructions and the ABNM Policy and Procedure manual carefully before completing this Application.

 Testing Period

 Testing period for which you are applying:
 Month:
 Year:
 Year:
 Year:

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 Please enter your Name exactly as it appears on your Government-Issued Photo I.D.

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If yes, please specify:								INTRAOPERATIVE MONITORING: O Less than 25% O 51 to 75%																				
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○ 3 ○ 4 to 5 ○ 6 to 10 ○ 0ver 10								I.																				
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Ε.	REGIONS OF THE NERVOUS SYSTEM WHERE YOU												Bill pr		insur	ance)											
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(Complete Page 2)



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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.

ABCDEF123456

Eli	gibility and Background	Information	Pag				
L.	PROFESSIONAL BACKGROUN	ID: Darken all that apply.) □ Neurosurgery	M. HAVE YOU TAKEN THIS EXAMINATION BEFORE?				
	☐ Anesthesia	☐ Orthopedics	If yes, indicate all instances and the month, year, and name under which the examination was taken.				
	Audiology	Chiropractic Medicine	Date (month/year):				
	Neurology	Other (specify)	Name:				
	🗌 Otolaryngology						

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 certification.

Race:		Age Range:		Gender:
O African American	O Native American	O Under 25	🔾 40 to 49	○ Male
⊖ Asian	O White	🔿 25 to 29	🔿 50 to 59	○ Female
O Hispanic	O Other	🔿 30 to 39	O 60+	

Candidate Signature

COMPLETE ENTIRE APPLICATION BEFORE SIGNING BELOW.

I have read the ABNM Policy and Procedure Manual, which is published on www.abnm.info, and understand that I am responsible for knowing its contents. I certify that the information given in this application is in accordance with the ABNM Policy and Procedures Manual and is accurate, correct, and complete.

CANDIDATE SIGNATURE: __

_ DATE: _

CREDIT CARD PAYMENT If you want to charge your application fee on your credit card provide all of the following information.	FOR OFFICE USE ONLY
Name (as it appears on your card):	Date
Address (as it appears on your statement):	
Charge my credit card for the total fee of: \$	
Expiration date (month/year):	Fee:
Card type: 🔿 Visa 🔿 MasterCard 🔿 American Express	CC Check
Card Number:	
SIGNATURE:	

