



Canadian Society of Clinical Neurophysiologists

EMG EXAMINATION – APPLICATION FORM

Surname: _____ Given Name: _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Email _____

The written and oral components of this examination will be offered in English and French. Please indicate which language you require (Note: You must select ONE at the time of your application; you cannot change your selection at the time of the examination). ENGLISH FRENCH

MEDICAL TRAINING (PROVIDE COPY OF DIPLOMA)

Years: 20 ____ - 20 ____

Medical School: _____

SPECIALTY TRAINING (PROVIDE COPY OF DIPLOMA OR LETTER FROM PROGRAM DIRECTOR)

Specialty: _____

Year of Diploma Obtained or Expected: _____

University: _____

EMG Training – Location, Periods of Training, Name of Training Director(s):

EMG EXPERIENCE AND CURRENT APPOINTMENT:

THE FOLLOWING ARE REQUIRED:

- Examination Fee of \$400.00
- Application Fee of \$400.00
- Recent Picture (passport size) dated and signed
- Copy of Medical Diploma
- Copy of Medical Specialty Certificate
- Letter from Program Director stating specialty eligibility if in final year of training
- Confirmation of EMG Training (to be filled out and sent by Training Director ONLY IF TRAINING IS COMPLETE). If training is not completed, send as soon as it is and prior to the examination date.



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CONFIRMATION OF EMG TRAINING

NOTE: Fill in ONLY when all training is completed and send prior to examination date.

Candidate Name: _____

Dates and Duration of Full-time Training

(at least 4.5 days/week with formal education program – Requirement of at least 3 months)

Dates and Duration of Part-time Training

(Requirement equivalent to 3 further months of full time training i.e. 60 days or 120 half days of training)

Approximate number of EMG studies performed by candidate during training (minimum 400 studies):

I hereby certify that the candidate has successfully completed EMG training and is suited to practice clinical EMG.

Name of Training Director (please print)

Signature of Training Director

Date

PLEASE RETURN TO:
CSCN Secretariat
709 7015 MacLeod Trail SW Calgary, AB T2H 2K6
Tel: (403) 229-9544 FAX: (403) 229-1661