



# Canadian Society of Clinical Neurophysiologists

## EMG EXAMINATION – APPLICATION FORM

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to become a member of CSCN ? Yes  No

### MEDICAL TRAINING (PROVIDE COPY OF DIPLOMA)

Years: 19\_\_\_\_ - 19\_\_\_\_

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:

- Application Fee of \$300.00
- 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.

**PLEASE RETURN TO THE ADDRESS BELOW**



# Canadian Society of Clinical Neurophysiologists

## 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.

\_\_\_\_\_  
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**