



Canadian Society of Clinical Neurophysiologists APPLICATION FOR CSCN EEG EXAMINATION

All items on this application form must be filled out, even if only with one word "none" or "not applicable"
TYPE OR PRINT LEGIBLY IN BLACK INK

Name	First Name	Middle Name
Institution	Department	
Address	City/ Province	Postal Code
Telephone	Extension	E-mail

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

Medical School	Year Attended
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POST GRADUATE MEDICAL TRAINING

	HOSPITAL	LOCATION	DATES	SPECIALTY
1				
2				
3				
4				
5				
OTHER				

DEGREES HELD	DATES AWARDED	INSTITUTION

FORMAL ELECTROENCEPHALOGRAPHIC TRAINING

LOCATION	TRAINING DIRECTOR	DATES

NUMBER OF RECORDS INTERPRETED PER YEAR DURING TRAINING

Total Full-time Training	Residency	Post Residency
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Other Formal EEG Training



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EXPERIENCE IN EEG POST-TRAINING (IF ANY)

LOCATION	DATES RECORDS INTERPRETED/ YEAR

CURRENT HOSPITAL AND/ OR UNIVERSITY POSITIONS

ROYAL COLEGE FELLOWSHIP

Specialty	Date
Specialty	Date

CERTIFIED IN EEG IN THE PROVINCE OF QUEBEC (ATTACH COPY OF DIPLOMA)

No	Yes	Year
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SPECIALTY PROGRAM DIRECTOR VERIFICATION

PROGRAM DIRECTOR

If formal EEG training was obtained at more than one location, the program director **at each** must be listed. When completed, the director should return the attached form *directly* to our office. These letters should confirm that training indicated on this application has been completed.

EEG TRAINING DIRECTOR VERIFICATION

EEG PROGRAM DIRECTOR

If formal EEG training was obtained at more than one location, the program director **at each** must be listed. When completed, the director should return the attached form *directly* to our office. These letters should confirm that training indicated on this application has been completed.

\$ 1,100 (NON-REFUNDABLE)

PLEASE RETURN THE COMPLETED APPLICATION WITH YOUR PAYMENT *AND A RECENT PICTURE (PASSPORT SIZE) DATED AND SIGNED TO:*

Dr. MARTIN VEILLEUX, EXAMINING COMMITTEE, CSCN
c/o CANADIAN NEUROLOGICAL SCIENCES FEDERATION

applications accepted via e-mail to marika-fitzgerald@cnsfederation.org or by fax 403-229-1661

Date Signature



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DR. MARTIN VEILLEUX
EXAMINING COMMITTEE, CSCN
c/o CANADIAN NEUROLOGICAL SCIENCES FEDERATION
by e-mail marika-fitzgerald@cnsfederation.org or via fax 403-229-1661

TRAINING DIRECTOR VERIFICATION OF ELECTROENCEPHALOGRAPHY &, CLINICAL NEUROPHYSIOLOGY TRAINING

CANDIDATE'S NAME _____

LOCATION OF FORMAL ELECTROENCEPHALOGRAPHIC TRAINING

DATES AND DURATION OF TRAINING

Duration Full-time Training _____ Start Date _____ End Date _____

Duration Part-time Training _____ Start Date _____ End Date _____

CANDIDATE COMPLETE TRAINING SATISFACTORILY?

IS THIS CANDIDATE CAPABLE OF APPROPRIATE, INDEPENDENT INTERPRETATION OF EEGS AND DO YOU RECOMMEND THIS CANDIDATE FOR EXAMINATION? YES NO

OTHER COMMENTS

NAME OF TRAINING DIRECTOR _____

SIGNATURE OF TRAINING DIRECTOR _____

YEAR CERTIFIED BY THE ROYAL COLLEGE _____

DATE _____

PLEASE RETURN TO THE ABOVE ADDRESS (PHOTOCOPY THIS PAGE IF NECESSARY)



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DR. MARTIN VEILLEUX
EXAMINING COMMITTEE, CSCN
c/o CANADIAN NEUROLOGICAL SCIENCES FEDERATION
by e-mail marika-fitzgerald@cnsfederation.org or via fax 403-229-1661

SPECIALTY PROGRAM DIRECTOR VERIFICATION

CANDIDATE'S NAME _____

LOCATION OF FORMAL NEUROLOGY/ NEUROSURGICAL TRAINING

DATES AND DURATION OF TRAINING

Duration Full-time Training _____ Start Date _____ End Date _____
Duration Part-time Training _____ Start Date _____ End Date _____

DID THIS CANDIDATE COMPLETE TRAINING SATISFACTORILY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THIS CANDIDATE SUITED TO PRACTISE NEUROLOGY OR NEUROSURGERY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ELIGIBLE OR PASSED ROYAL COLLEGE FELLOWSHIP EXAMINATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO

OTHER COMMENTS

NAME OF TRAINING DIRECTOR _____

SIGNATURE OF TRAINING DIRECTOR _____

YEAR CERTIFIED BY THE ROYAL COLLEGE _____

DATE _____

PLEASE RETURN TO THE ABOVE ADDRESS