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

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

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

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.

$ 1,300 (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
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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

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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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EXAMINING COMMITTEE, CSCN
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SPECIALTY PROGRAM DIRECTOR VERIFICATION

CANDIDATE'S NAME ______________________________

LOCATION OF FORMAL NEUROLOGY/ NEUROSURGICAL TRAINING

____

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____

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?	☐ **YES** ☐ **NO**
IS THIS CANDIDATE SUITED TO PRACTISE NEUROLOGY OR NEUROSURGERY?	☐ **YES** ☐ **NO**
ELIGIBLE OR PASSED ROYAL COLLEGE FELLOWSHIP EXAMINIATION?	☐ **YES** ☐ **NO**

OTHER COMMENTS

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NAME OF TRAINING DIRECTOR ______________________________

SIGNATURE OF TRAINING DIRECTOR ______________________________

YEAR CERTIFIED BY THE ROYAL COLLEGE ______________________________

DATE ______________________________