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

Canadian Society of Clinical Neurophysiologists

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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.

$ 1,500 (NON-REFUNDABLE)

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

Dr. MARCUS NG, EXAMINING CIOMMITTEE, CSCN
c/o CANADIAN NEUROLOGICAL SCIENCES FEDERATION
applications accepted via e-mail to marika-fitzgerald@cnsf.org

Date _____ Signature _____

Canadian Society of Clinical Neurophysiologists
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DR. MARCUS NG
EXAMINING COMMITTEE, CSCN
c/o CANADIAN NEUROLOGICAL SCIENCES FEDERATION
by e-mail marika-fitzgerald@cnsf.org

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)*

Canadian Society of Clinical Neurophysiologists

APPLICATION FOR CSCN EEG EXAMINATION

DR. MARCUS NG
EXAMINING COMMITTEE, CSCN
c/o CANADIAN NEUROLOGICAL SCIENCES FEDERATION
by e-mail marika-fitzgerald@cnsf.org -

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

OTHER COMMENTS

_____

_____

NAME OF TRAINING DIRECTOR _____

SIGNATURE OF TRAINING DIRECTOR _____

YEAR CERTIFIED BY THE ROYAL COLLEGE _____

DATE _____