

**The American Board of Pediatric Neurological Surgery**

Application for the ABPNS Written Examination

**Please read carefully and check the appropriate boxes (double left click and then choose “checked”. Application will not be processed until complete.**

**Part I: Contact and Practice Information**

**Name:**

**Office Address:**

 **Institution:**

 **Street:**

 **City: State or Province:**

**Zip Code: Country:**

**Home Address:**

**Preferred Mailing Address: □Home □Office**

**Phone:**

**Home/Cell:**

**Fax:**

**E-mail:**

**Fellowship:**

 **Institution:**

 **ACPNF-accredited slot? (Y/N)**

 **Dates of Training:**

 **Director:**

**Residency Program:**

 **Institution:**

 **Dates of Training:**

**Medical School:**

 **Institution:**

 **Dates of training:**

**Date started practice at current Institution:**

**[ ]**  **No restrictions** **[ ]**  **Restricted**

 **If restrictions, please explain:**

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

**Part II: Professional Standing**

1. **Have you received any type of sanction or are you currently** **[ ]  Yes** **[ ]  No**

**under investigation by a hospital, state licensing agency, or**

**other healthcare organization?**

1. **Have you voluntarily or involuntarily surrendered, retired or**

**relinquished ANY licensure or registration?** **[ ]  Yes** **[ ]  No**

1. **Have you had or do you currently have successful challenges** **[ ]  Yes** **[ ]  No**

 **to your DEA or state-controlled substance registration?**

1. **Have your privileges at ANY hospital or healthcare facility** **[ ]  Yes** **[ ]  No**

**been limited, reduced, suspended, diminished, revoked, or not**

**renewed by the action of any hospital or healthcare facility?**

1. **Has your faculty membership at ANY medical center or other** **[ ]  Yes** **[ ]  No**

**Professional school been removed or subject to disciplinary**

**action?**

**If you answered YES to any of the questions numbered 1 through 5, please explain in the section immediately below:**

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

**Licensure Information**

**STATE OR PROVINCE LICENSE NUMBER RESTRICTED OR SUSPENDED**

**­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ]  Yes** **[ ]  No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ]  Yes** **[ ]  No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ]  Yes** **[ ]  No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ]  Yes**  [ ]  **No**

**Supporting documentation accompanying this application. Please check off:**

[ ]  Proof of Residence in U.S. or Canada. (Can be a copy of a driver’s license).

[ ]  Letter of good standing from fellowship director or copy of fellowship certificate.

[ ]  Copy of Residency certificate.

[ ]  Copy of Medical License.

[ ]  Copy of Royal College of Physicians and Surgeons of Canada (RCPS-C) certificate if applicable.

[ ]  Letter of good standing from current Institution.

 Please note that the application should be complete and in the hands of the Credentialing Committee within one year of completion of your ACPNF-accredited pediatric neurosurgery fellowship program. You will have two opportunities to apply: by October 1st to be considered for the winter written exam (offered at the time of the Pediatric Section meeting), or by April 1st to be considered for the June exam at the time of the ABPNS Board of Directors meeting. If your application is approved by the Board, you will be eligible to sit for the ABPNS written examination. Please submit this application and the supporting documentation listed above electronically via e-mail to Abpns.secretary@mch.com.

 Those applying for the written examination should send in the examination fee in the amount of $750 at the time of application. The examination fee can be paid by check or online using a credit card. Please make check payable to the American Board of Pediatric Neurological Surgery and mail attention to the ABPNS Secretary-Treasurer. If paying online, you can find the Amazon pay button on the home page of the ABPNS website.

By signing below, I hereby verify that all information submitted in this is true, accurate and completed to the best of my knowledge and belief.

Electronically signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type in your name to verify above)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_