

**The American Board of Pediatric Neurological Surgery**

Application for Board Certification for Non-ACPNF Fellowship Trained

Pediatric Neurosurgeons via the Alternate Pathway

(Requiring submission of a 5 year case log)

**Please read carefully and check (left click and then choose “checked”) the appropriate boxes.**

**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:**

**Dates of Training:**

**Director:**

**Residency:**

 **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:**

[ ]  Copy of American Board of Neurological Surgery Certificate in pdf format, if applicable.

[ ]  Copy of RCPSC certificate in pdf format, if applicable.

[ ]  Copy of Medical License in pdf format.

[ ]  Letter of good standing from current hospital, institution.

[ ]  Copy of Certificate from Residency Training in pdf format.

[ ]  CME’s listed for immediate past 3 years (at least 20 CME credits AMA PRA category 1 or equivalent in Neurosurgery each year)

[ ]  Provide a case log with past 5 years of all cases (adults and children). Please note that the case log cannot cover a period that begins more than **66 months** prior to the intended date for sitting for the exam. If the applicant must postpone his or her test date or retake the test it will be at the discretion of the Board as to whether or not the case log must be updated. Please contact the ABPNS Secretary via email at Abpns.secretary@nicklaushealth.org for the current case log spreadsheet, means of submitting practice data.

[ ]  Current CV

[ ]  A paragraph explaining why sub specialization in pediatrics is important to you.

**CASE LOG REQUIREMENTS FOR CERTIFICATION by the ABPNS:**

\*\*Current case log requirements are listed on the ABPNS website.

Please note that the application **must** be completed and in the hands of the Credentialing Committee by April 1st for review at the June Board meeting or by October 1st for review at the December Board meeting. If your application is approved by the Board, you are eligible to sit for the pediatric written/online examination. If your application is incomplete or received after the deadline date, your application will be processed for the following test date and the case log may need to be updated. Please submit this application and the supporting documentation listed above electronically via e-mail to Abpns.secretary@nicklaushealth.org

There is an examination fee due at the time of application. Please contact the ABPNS secretary regarding the current fee schedule and method of payment.

By signing below, I hereby verify that all information submitted in this application for Certification via the Alternate Pathway by the ABPNS is true, accurate and completed to the best of my knowledge and belief. I hereby request Certification via the Alternate Pathway by the ABPNS. I understand that Certification will require the submission of an operative case log and the successful completion of a pediatric written/online examination and oral examination.

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

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