111 E. University Dr., Ste. 105–355
Denton, TX 76209
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ABRET Accreditation

LAB-EEG INTRODUCTION & STANDARDS

Routine EEG Testing

General Information

The Laboratory Accreditation Boards of ABRET are separate boards functioning under ABRET Neurodiagnostic Credentialing and Accreditation, Inc. as part of ABRET's Mission. ABRET is a not-for-profit, 501 c6 corporation.

Eligibility

Any laboratory performing clinical EEGs interpreted by a licensed physician (M.D., D.O., or equivalent) may apply for accreditation.

- At least one of the staff technologists must be an R. EEG T. or Canadian R.E.T.
- The lab must be under the direction of a physician with a current medical license.
- The lab must have at least one year of EEG data eligible for submission if requested.

It is highly recommended that you have confidence all recordings performed in the last year (12 months prior to application) meet ACNS Technical Standards (refer to pages 5–6 below).

LAB-EEG is re-examining their policies and is not accepting accreditation applications for organizations that only perform home studies or ambulatory studies at this time.

Accreditation

LAB-EEG accreditation requires a formal review of EEG data, policies and procedures. The EEG interpretation (professional component) will not be evaluated. A site visit is not required.

Accreditation will be for five years.

A list of LAB-EEG accredited laboratories will be published. Successful laboratories will receive a framed certificate; digital certificate, digital badge, and press release.

Unsuccessful laboratories may reapply in one year.

APPLICATION REQUIREMENTS for EEG LABORATORY ACCREDITATION

Step One
Complete steps 1–8 of the online application (https://lab-program.abret.org/login/), including:

- Detailed responses as to how the lab meets the **Standards 1 – 4** defined below.
- Signed Application Agreement, which includes acknowledgement of receipt of ABRET Accreditation Policies (pages 7–18 below) (download the application agreement and upload the signed copy in Step 9 of the online application).
- Although it is expected that all EEG recordings have been appropriately de-identified, a Business Associate Agreement (BAA) must be completed and in place to satisfy HIPAA requirements (upload BAA in Step 7 of the online application). **If the applicant facility prefers to use the facility-based BAA, please upload a copy to the application for signature.**

Step Two
Submit five (5) routine EEG recordings as described in **Standard 5** (pages 3–4 below).

- **A link for uploading your recordings** will be added to Step 9 of your application within 3–5 business days after Steps 1–8 are completed. You will be notified by email when the link is available in your application.

Remit payment of the $1500.00 accreditation fee by check payable to ABRET or pay online through the application portal by credit card.

- An Invoice will be available in your online application dashboard. If you require a W-2 for processing, contact applicationsupport@abret.org.
- Once payment is made, the invoice will be updated to confirm payment with $0 due.
- Checks should be made payable to ABRET, ***including invoice number***, and be mailed to:

ABRET LAB-EEG
111 E. University Drive, Ste. 105–355
Denton, TX 76209

REMINDER: It is important to review your application in detail before submitting it as you will not have access to make changes after submission.

EEG ACCREDITATION STANDARDS

Standard 1
The lab should be staffed by qualified technologists who have met national competency standards.

Submit a list of all staff technologists, including credential numbers. At least one staff member must have a current R. EEG T. or Canadian R.E.T. credential. If not all staff are credentialed, a policy must be in place detailing how competency is determined and expectations for ensuring all staff earn credentials.

Standard 2
The lab should support the continuing education of staff and expect staff to keep current in the field of EEG.

What is the professional development plan for your technologists? How is continuing education encouraged, expected, and supported? Submit a list of all staff continuing education activities over the last 12 months.

Standard 3
The lab must have a Medical Director with a current license to practice medicine.

A copy of the Medical Director's State Medical License must be submitted. What is the role of the medical director in your lab? Does s/he provide guidance and feedback to the technologists regarding performance?

Standard 4
The lab must have policies in place that address staff and testing procedures.

Upload Departmental and Procedural policies addressing the following (only the requested policies should be submitted, do not include extraneous information):

1. Staff and Department Policies
    a. Staffing policies for technical personnel (Job Descriptions/Competencies)
    b. Technologist education (required continuing education)
    c. Infection prevention policy (specific to the EEG Department)
    d. Patient safety (specific to the EEG Department)
    e. Electrical safety (specific to the EEG Department)
    f. Quality improvement policy/project (specific to EEG Department)

2. Testing Procedure Policies must be submitted for all routine EEG procedures performed by the lab, including (not required if not performed by the lab):
    a. Routine EEG
    b. Pediatric EEG
    c. Neonatal EEG
    d. Bedside EEG
    e. Sleep deprived EEG
    f. EEG for Determination of Electrocerebral Inactivity (ECI)

Standard 5
The lab must submit five (5) routine EEG recordings performed in the last 12 months as described below. Long-term recordings, intraoperative recordings or ambulatory studies **will not be accepted**.

A Recording ID form, defining recordings #4 and 5 described below, will be hyperlinked to Step 9 of your application 3-5 business days after you complete Step 8 of the online application. You will be notified by email when the link has been added to your application.

Recordings 1-3 Three (3) routine EEGs selected by the applicant lab identified as Normal, Focal abnormality, and Generalized abnormality.

- At least one (1) facility-selected recording **must capture stage ≥N2 sleep** and this recording must be identified in the Recording ID form.
- **Pediatric programs** must submit at least one recording of a patient ≤ 2 years old and this recording must be identified in the Recording ID form.
- It is expected the three applicant-selected recordings were acquired by different technologists. If there are only two technologists working in the lab, one may have performed two of the three EEG recordings.

Recordings 4-5 Two (2) randomly selected routine EEGs requested by the EEG Board. Selection is made by the date of the recording and will be identified in the Recording ID Form as described above. If random recordings are not continuous, please submit your policy for clipping and archiving.

- **Do not** submit routine EEG recordings that exceed one (1) hour.
- Records must be submitted with reading software. Verify the review software opens the recordings properly on a generic PC running Windows, and not just on your review station, and that **the data is displayed AS RECORDED, including settings, impedances, montages, and all annotations.**
- Title each recording, identifying which is normal, focal and generalized and which were selected by ABRET.
- **Recordings should adhere to the ACNS Guidelines.** See the *Expected Technical Standards for Recordings* included in this document on pages 5–6.
- **Patient identifying information should be removed.** While PHI should be removed, some patient details (e.g., medications, referral reason, last symptom date) are needed to facilitate a thorough review. If de-identifying recordings removes this info, **uploading screenshots/images of the recording technologist's annotations (with sensitive info marked out) along with the recordings is acceptable**.
- Although PHI is removed, a BAA must still be completed to satisfy HIPAA requirements. Use either ABRET BAA template found in the online application or your own institutional agreement form. Data will only be used for evaluation and will be destroyed or deleted at the completion of the evaluation.

Submission of Multiple Applications and Associated Fees

EEG laboratories utilizing the same technologists, medical director, and administration may be eligible for dual accreditation. Labs may apply for accreditation jointly if they agree to pass or fail as a group. Requested records must represent both labs. Alternatively, related labs may prepare separate applications. Applications must be submitted together for a 20% discount for the second lab.

Adult and Pediatric labs within the same hospital must prepare separate applications and submit together for a 20% discount for the second lab. Requested records must represent both labs.

Each lab will receive a framed certificate.

EXPECTED TECHNICAL STANDARDS FOR EEG RECORDINGS

1. All recordings must be interpretable.
2. All facility-selected records must have been recorded within twelve (12) months of the application.
3. Every record must contain a minimum of sixteen channels of EEG. ACNS Guideline 1, 1.1
4. All inter-electrode impedances (not greater than 10,000 ohms)* must be documented. Inter-electrode impedances must be balanced within 4k Ohms. ACNS Guideline 1, 2.4
5. Required documentation: Patient Age, Date, Tech Name or ID. A unique procedure or log number should be included. ACNS Guideline 1, 3.1
6. Required documentation: Time of Recording, Time and Date of Last Symptom or Event, Behavioral State of Patient, Medication, Summary of Relevant Medical History.

   Recordings should not contain any patient information beyond the required documentation. If de-identifying recordings removes this info, uploading screenshots/images of the recording technologist's annotations (with sensitive info marked out) along with the recordings is acceptable.
7. Square wave calibration for 10 seconds at the beginning of the recording. Ideally, the first 30 seconds of recording should be observed by the technologist from the primary system reference montage. (Bio-cal is of no use in digital recordings) ACNS Guideline 1, 3.2
8. Scalp recording standards:
   Sensitivity of 5-10 µv/mm is required, and should be adjusted as needed.
   Low-frequency filter not greater than 1.6 Hz (time constant of not <0.16 seconds) is required, and adjusted as needed.
   High-frequency filter 70 Hz is required and adjusted as needed.
   Digital display (paper) speed of 30mm/sec or a digital display of 10 seconds/page is required.
   The 60 Hz notch filter should be used appropriately, and not defaulted to "on." ACNS Guideline 1, 3.3-3.6
9. Any artifacts should be corrected, mitigated, and documented, as necessary.
10. A <u>minimum</u> of 20 minutes of artifact-free EEG activity, not including calibrations, is required. ACNS Guideline 1, 3.7
11. At least three (<u>3</u>) different montages must be recorded*, including at least <u>one bipolar</u>, and <u>one referential montage</u> for a minimum of one minute each. ACNS Guideline 1, 3.7
12. The montages must be complete and appropriate to demonstrate abnormality.
13. There should be at least one period of eye opening/eye closure. ACNS Guideline 1, 3.8
14. Hyperventilation should be performed and acceptable with effort noted or contraindicated with reason documented. ACNS Guideline 1, 3.8
15. Photic stimulation should be performed and acceptable or contraindicated. ACNS Guideline 1, 3.8
16. Adequate sleep recording should be obtained, attempted, or not needed. At least one submitted record must contain stage two (n2) sleep. ACNS Guideline 1, 3.9
17. Visual, auditory, or somatosensory stimulation should be used and documented, as appropriate. ACNS Guideline 1, 3.10
18. Digital display speed (paper speed), sensitivity, filters, and montages must be clearly identified on the record and at times of change.

19. The patient's state and/or level of consciousness (awake, drowsy, sleep, comatose, etc.) and any changes should be clearly noted on the record. ACNS Guideline 1, 3.10
20. Complete descriptions of patient events, movements, and tech instructions should be clearly noted on the record at the time of occurrence. ACNS Guideline 1, 3.10
21. Clear documentation of patient's maximal level of alertness must take place at some time during recording. ACNS Guideline 1, 3.10
22. Recordings must be recorded continuously without deletion of pages or demonstrate a continuous time and montage sequence as recorded.

    Note: Recording on one montage and submitting a reformatted recording is not acceptable.
23. Before submitting data, verify it is viewable on a generic PC running Windows, and not just on your review station.
24. Verify the review software opens the recordings properly, and that **the data is displayed AS RECORDED, including settings, impedances, montages, and all annotations.**
25. Label each recording, identifying which is normal, focal and generalized and which were selected by date by ABRET.
26. Provide additional information/instructions as to how to use your particular reading software.

*2016 ACNS Guideline 1: Minimum Technical Requirements for Performing Clinical EEG

REFERENCES

1. American Clinical Neurophysiology Society Guidelines (www.acns.org)
   a. Minimal Technical Requirements for Performing Clinical Electroencephalography, Guideline 1
   b. Recording Clinical EEG on Digital Medica, Guideline 4
   c. Minimal Technical Standards for Pediatric Electroencephalography, Guideline 5
2. ASET: The Neurodiagnostic Society (www.aset.org)
   a. EEG National Competencies
   b. Minimum Education and Credentialing Recommendations
   c. Scope of Practice for Neurodiagnostic Technology
   d. Neurodiagnostic Practice Levels
   e. Policy & Procedures for the Neurodiagnostic Department: Reference Manual
3. National Association of Epilepsy Centers, "Guidelines for Essential Services, Personnel, and Facilities in Specialized Epilepsy Centers." (www.naec-epilepsy.org)
4. The Joint Commission, "National Patient Safety Standards."(www.jointcommission.org)

ABRET LABORATORY ACCREDITATION POLICIES

ACCREDITATION DECISION REVIEW & APPEAL POLICY

ABRET has adopted this policy to establish a fair process for addressing application issues.

1. Initial Review. ABRET will determine whether a facility has met the requirements for accreditation. It may decide: (i) to grant accreditation, or (ii) to require the facility to submit additional evidence of compliance. Additional evidence of compliance may include a site visit. The timeframe and other conditions for further review will be provided by ABRET in writing.

2. Adverse Action Allegations. ABRET may place an application on hold while allegations of misconduct are pending.

3. Denial. Accreditation may be denied for reasons that include (but are not limited to) the following:

- **A.** failure to truthfully complete and sign an application in the form provided by ABRET;
- **B.** failure to pay the required fees;
- **C.** failure to provide additional information as requested;
- **D.** refusal to allow a site visit;
- **E.** the facility has submitted the maximum of three supplemental information responses and ABRET remains unable to confirm that the facility meets the requirements for accreditation; and
- **F.** grounds exist for adverse action as described in the Adverse Action policy.

4. Notification. ABRET will notify the facility within 30 calendar days after it makes its decision.

5. Decision Appeals Process.

- **A.** Only "Denial" decisions can be appealed.
- **B.** A failure to comply with any ABRET deadline may not be appealed.
- **C.** A facility may request an appeal within 30 calendar days after notification of the denial decision. After this time, the facility may not request an appeal.
- **D.** Appeal requests must be submitted in writing and sent to ABRET by traceable mail or delivery service.
- **E.** The appeal must specify a valid basis for the appeal. If ABRET determines that the request is frivolous, then the appeal will not proceed.
- **F.** ABRET may file a written response to the appeal request.
- **G.** ABRET will appoint an Appeal Committee to consider the appeal. The Appeal Committee is composed of three members selected from the ABRET Board of Directors. Appeal Committee members may not: (a) be the same individuals who initially reviewed the application, (b) review any matter in which their impartiality might reasonably be questioned, or (c) review any matter which presents an actual, apparent, or potential conflict of interest. Committee action is determined by majority vote.

H. The Appeal Committee will render a decision based on the written record. Documentation not previously submitted to ABRET will not be considered. An oral hearing is not permitted.

I. The Appeal Committee may accept, reject, or modify the denial decision. In order to overturn the decision, the facility must demonstrate that the denial decision was inappropriate because of: (a) material errors of fact, or (b) failure to conform to ABRET's rules.

J. The decision of the Appeal Committee is final.

K. ABRET will notify the facility of the decision of the Appeal Committee in writing.

L. Only one appeal per application is permitted. If that appeal upholds the original denial, then the facility must complete and submit a new application in order to seek accreditation at another time.

M. The facility is responsible for all expenses incurred by it related to the appeal and must pay any administrative appeal fee charged by ABRET.

6. Reinstatement of Eligibility. Following a denial based on this policy or other noncompliance with ABRET Standards, policies, and procedures, a subsequent application will not be reviewed unless the facility demonstrates that it has undertaken corrective action.

RELEASE OF INFORMATION POLICY

ABRET has adopted this policy to inform applicants and accredited facilities of how information may be released.

1. Interested parties may request verification of accreditation.

A. Requests may be made to the Executive Office.

B. Accreditation verification forms are available from the office or website.

C. Accreditation may be verified online on the ABRET website. If accreditation is granted, ABRET will publish the facility's accreditation status and the expiration date in a directory of accredited laboratories.

2. Appropriate information must be provided for the verification.

A. The request must include the name and address of the facility.

B. The Executive Director sends a confirmation of accreditation along with the date of accreditation and expiration to the requesting party.

C. If the Executive Director experiences a conflict or is unclear of the facility's status, additional information is requested.

3. ABRET does not release information on the status of a pending application. The Executive Director may, however, upon written authorization from the facility, confirm or deny that a facility has a pending application.

4. Accreditation decisions will not be disclosed until written notice of that decision has been sent to the facility.

5. ABRET may also publish whether any adverse action has been taken regarding a facility, such as revocation or suspension of accreditation. Regarding adverse actions, ABRET will release the effective date of the action and a summary of the reasons for the action.

Information regarding adverse actions is released only after the facility's right of appeal has been exhausted.

6. ABRET rents its mailing list to organizations and companies who offer products that might be of interest to facilities. A facility may opt-out of this mailing list by contacting ABRET.

7. ABRET shares data about facilities for research purposes. No patient identifiable information is provided. A facility may opt-out of data sharing by contacting ABRET.

8. As a general policy, all other facility and ABRET information is treated as confidential and privileged. ABRET will, in its discretion, exercise sound judgment with respect to assistance in investigations by other parties, such as a regulatory agency, another accreditation organization, or a payer. However, ABRET must release information as required by law or court order, and will notify governmental agencies if it discovers a performance deficiency that violates federal, state or local laws or otherwise presents a threat to the public.

REPORTING CHANGES POLICY

ABRET has adopted this policy to provide guidance to accredited facilities regarding when and how to report changes to ABRET.

1. Changes to the ABRET Standards, Policies, and Procedures. Accredited facilities are expected to maintain continuous compliance with the Standards and other ABRET policies and procedures, including changes to the Standards that occur during the five-year accreditation period. Facilities will be notified of changes, and revised Standards, policies, and procedures will also be published on the ABRET website.

2. Facility Changes.

- **A.** Accreditation is awarded to the facility as its operations are described on its application. A facility shall report to ABRET any change regarding the facility's operations or other development that is related to accreditation. Facilities are expected to notify ABRET in writing within 90 calendar days after the facility first learns of the development, and must provide documentation of the resolution of the matter within 90 calendar days after resolution. Examples of information that must be reported include (but are not limited to):
  - **i.** contact information changes;
  - **ii.** personnel changes, including medical director;
  - **iii.** changes in the facility's address or the location(s) where services are provided;
  - **iv.** changes in ownership or management of the facility;
  - **v.** discontinuing a service or ceasing to do business;
  - **vi.** being investigated or sanctioned for fraud or other misconduct by a government agency; and
  - **vii.** being sued by a patient.
- **B.** Regarding personnel changes, the facility shall notify ABRET of the departure of personnel and shall submit a replacement plan within 30 calendar days.

C. Regarding ownership changes, accreditation cannot be transferred without written approval from ABRET. Accreditation may not be divided or shared following a sale, dissolution or other change in ownership or legal structure.

D. ABRET will review the change to determine whether the facility's existing accreditation remains valid following the change or if the change requires the facility to re-apply for accreditation. ABRET may require the facility to submit additional evidence of continuing compliance.

ACCREDITATION TRADMARK POLICY

ABRET permits laboratories and other facilities to use the ABRET name to state the fact of accreditation in accordance with this policy as long as active accreditation is maintained.

1. Ownership. The acronym "ABRET", the name "ABRET Neurodiagnostic Credentialing and Accreditation," and the accreditation certificates and other emblems of ABRET are the sole and exclusive property of ABRET and are subject to all applicable trademark and other rights of ABRET as owner under United States intellectual property law and international conventions. Facilities shall not use these items, or any other intellectual property owned by ABRET, except as expressly authorized in this policy or otherwise authorized in advance and in writing by ABRET.

2. License. For the duration of accreditation, ABRET will permit an accredited facility to use the ABRET name and accreditation certificate for the sole purpose of indicating accreditation by ABRET. All goodwill associated with these items as used by accredited facilities inures solely to the benefit of ABRET.

3. Permitted Uses. Facilities may display the accreditation certificate at its accredited location(s). Facilities may use the ABRET name on:

A. letterhead and business cards;
B. websites; and
C. advertisements, brochures, and other promotional materials.

4. Conditions of Use.

A. All use of the ABRET name must be accurate and supportive of ABRET objectives, and must do so in a manner that is compatible with the mission of ABRET.
B. All use of the ABRET name must be truthful and not misleading. Specifically, a facility shall not use this name:
   i. unless ABRET has made an official accreditation decision;
   ii. in connection with services or testing areas in which the facility is not accredited;
   iii. in any manner that reflects negatively on ABRET or its activities;
   iv. in any manner that conflicts with ABRET policies and procedures;
   v. to state or imply that the facility has any relationship with ABRET other than as an accredited facility; or
   vi. to state or imply that ABRET is endorsing or guaranteeing any product or service offered by the facility.

C. Facilities shall not use the ABRET name (or a word or design that is confusingly similar to an ABRET trademark) as part of the facility's business name, logo, domain name, or product or service name.

D. The ABRET name may not be the most prominent visual element on the facility's promotional materials. The facility's business name and/or logo, product or service name, and graphics should be significantly larger than the reference to ABRET accreditation.

E. If space permits, then use of the ABRET name must be accompanied by an acknowledgement of ABRET ownership. This acknowledgement should appear as a footnote with the copyright notice, at the end of a printed document, or at the bottom of a webpage. Please include the following acknowledgement: The ABRET name is a registered trademark owned by ABRET Neurodiagnostic Credentialing and Accreditation and is used by permission.

F. If accreditation ends, then the facility shall:

vii. cease use of any statement that indicates active ABRET accreditation;

viii. return all certificates and other items provided by ABRET, without retaining copies; and

ix. not distribute any materials containing a statement of active ABRET accreditation that the facility might already have prepared.

G. The facility is responsible for correcting (at its expense) any outdated or otherwise inaccurate reference to active ABRET accreditation.

5. Quality Control. ABRET has the right to control the quality of all materials on which its name is used in a statement indicating active ABRET accreditation. ABRET will have access to the materials which the facility makes publicly available (such as business cards, letterhead, etc.). Also, the facility shall submit samples if requested by ABRET. If ABRET determines that the facility is not meeting the requirements of this policy, ABRET will notify the facility and provide an explanation. The facility shall correct the violation within 30 calendar days after receipt of the notice. ABRET is the final judge as to whether any use of the ABRET name is consistent with this policy.

6. Consequences of Misuse. ABRET is committed to protecting its intellectual property for the benefit of all accredited facilities and the general public as consumers. If a facility fails to comply with this policy or otherwise misuses an accreditation certificate, the ABRET name, or other intellectual property of ABRET, then ABRET may revoke or take other action with regard to the facility's accreditation status in accordance with the ABRET ACCREDITATION ADVERSE ACTION POLICY. If the facility is not accredited by ABRET at the time of the misuse, then ABRET will require corrective action as a condition of eligibility for accreditation should the facility seek accreditation at a later time. In addition, ABRET may pursue other remedies that may be legally available.

7. Further Information. If an individual has a question regarding use of these marks, please contact ABRET.

ADVERSE ACTION POLICY

ABRET has developed this Adverse Action policy to articulate standards of conduct for eligibility for accreditation and continued accreditation. This policy was also adopted to establish a fair process for addressing noncompliance with ABRET Standards, policies, and procedures.

1. **General Principles.** Facilities and their staff must:
   - **A.** be truthful, forthcoming, prompt, and cooperative in their dealings with ABRET;
   - **B.** be in continuous compliance with ABRET's Standards, policies, and procedures (as amended from time to time by ABRET);
   - **C.** respect ABRET's intellectual property rights;
   - **D.** abide by laws related to the profession and to general public health and safety; and
   - **E.** carry out their professional work in a competent and objective manner.

2. **Grounds for Adverse Action.** Grounds for adverse action include:
   - **A.** Providing fraudulent or misleading information;
   - **B.** Failure to pay fees when due;
   - **C.** Unauthorized possession or misuse of ABRET intellectual property;
   - **D.** Misrepresentation of accreditation status;
   - **E.** Refusal to allow ABRET to conduct an on-site visit, if requested;
   - **F.** Failure to provide requested information in a timely manner;
   - **G.** Failure to inform ABRET as required by the Reporting Changes policy;
   - **H.** Noncompliance with laws related to the facility's business or to general public health and safety;
   - **I.** Adverse action by a governmental agency or an accreditation or professional organization other than ABRET; and
   - **J.** Other failure to maintain continuous compliance with ABRET Standards, policies, and procedures.

3. **Sanctions.**

   - **A.** ABRET may impose one or more of the following sanctions for failing to adhere to ABRET Standards, policies, and procedures:
     - **i.** Denial of accreditation;
     - **ii.** Revocation of accreditation;
     - **iii.** Non-renewal of accreditation;
     - **iv.** Suspension of accreditation for a specific period of time;
     - **v.** Reprimand;
     - **vi.** Notification of other legitimately interested parties; or
     - **vii.** Other corrective action.

   - **B.** The sanction must reasonably relate to the nature and severity of the violation, focusing on reformation of the conduct of the facility and deterrence of similar conduct by others. The sanction decision may also take into account aggravating circumstances, prior adverse action history, and mitigating circumstances. No single sanction will be appropriate in all situations.

4. Compliance with ABRET Standards, Policies, and Procedures. A facility must be in continuous compliance with all ABRET Standards, policies, and procedures. Each facility bears the burden for demonstrating and maintaining compliance at all times.

5. Non-Payment of Fees. Failure to pay fees when due results in automatic suspension of accreditation. Accreditation may be reinstated if the facility pays all fees within thirty (30) days after the original due date. Failure to pay fees within this time period results in automatic termination of accreditation.

6. Complaints.

- **A.** Persons concerned with possible violation of ABRET rules are encouraged to contact ABRET. The person should submit a written statement identifying the facility alleged to be involved and the facts concerning the alleged conduct in detail, and the statement should be accompanied by any available documentation. The statement should also identify others who may have knowledge of the facts and circumstances concerning the alleged conduct. The person making the complaint should identify him-/herself by name, address, email address, and telephone number. However, ABRET will consider anonymous complaints as long as sufficient information is provided to enable ABRET to conduct an appropriate investigation.
- **B.** Actions taken under this Policy do not constitute enforcement of the law. Individuals bringing complaints under this Policy are not entitled to any relief or damages by virtue of this process.

7. Pending Allegations. ABRET may place an application on hold while allegations of misconduct are pending.

8. Establishment of Review Committee and Hearing Committee.

- **A.** The ABRET President will appoint a Review Committee and a Hearing Committee on an ad hoc basis as needed to consider alleged violations of ABRET Standards, policies, and procedures.
- **B.** Each of these Committees will be composed of five members drawn from current or former ABRET volunteers.
- **C.** A committee member may not simultaneously serve on more than one committee and may not serve on any matter in which his or her impartiality might reasonably be questioned, or which presents an actual or apparent conflict of interest.
- **D.** At all times during ABRET's handling of the matter, ABRET must exist as an impartial review body.
  - **i.** In order to avoid actual, apparent, or perceived conflicts of interest, no member is permitted to serve on the Review Committee or the Hearing Committee whenever:
    - **a.** A member has formed an opinion on the matter; or
    - **b.** A member is or has been employed by the facility that is the subject of the allegation; or
    - **c.** The member has special knowledge that could bias his/her decision relative to either the facility or ABRET.

ii. If anyone identifies a situation where the impartiality of a Committee member might reasonably be questioned, or which presents an actual or apparent conflict of interest:

a. The member shall make full disclosure of such matter by reporting the possible conflict or bias immediately to the Committee chair; and

b. The Board of Directors shall determine whether the member is permitted to continue to participate as a Committee member.

E. Each Committee shall elect its own Chair.

F. Committee action shall be determined by majority vote.

G. When a committee member is unavailable to serve by resignation, disqualification or other circumstance, the President of ABRET shall designate another individual to serve as an interim member.

9. Review Procedures.

A. Initial Evaluation by President.

i. Upon receipt of a complaint or a change notice, the Executive Director will confer with the President. The President or the Executive Director may request supplemental information.

ii. If the Executive Director and President determine that the complaint is frivolous or that the change is not relevant to certification, no further action will be taken.

iii. If the Executive Director and President determine that ABRET lacks jurisdiction over the complaint or the facility that is the subject of the complaint, then they may refer the matter to the appropriate governmental agency or another entity engaged in the administration of law.

iv. If the Executive Director and President determine that the complaint is not frivolous or that the change may be relevant to certification, it will be forwarded to the Review Committee for investigation.

v. Facilities submitting change notices and persons submitting complaints will be notified of the decision of the Executive Director and President.

B. Audits. ABRET may conduct one or more compliance audits. If ABRET discovers a possible violation of ABRET rules, the Executive Director will confer with the President to determine whether the allegation will be forwarded to the Review Committee for investigation.

C. Procedures of the Review Committee.

i. The Review Committee will investigate the allegations. The Review Committee may contact the individual who submitted the complaint, the facility in question, and others who may have knowledge of the facts and circumstances surrounding the allegations. They may conduct an investigative site visit.

ii. If the Committee determines that the facts are inadequate to sustain a finding of a violation of ABRET rules, no further action will be taken. Facilities submitting change notices and persons submitting complaints will be notified of this decision.

iii. If the Committee finds that good cause exists to question whether a violation of an ABRET rule has occurred, the Committee will transmit a statement of the following information to the facility by traceable delivery service, signature required:

- **a.** the applicable rule;
- **b.** the facts constituting the alleged violation;
- **c.** that the facility may request an oral hearing (in person or by phone) or a review by written briefing for the disposition of the matter, with the facility bearing its own expenses;
- **d.** that the facility has thirty (30) days after receipt of the statement to notify the President and the Committee if it disputes the allegations, has comments on available sanctions, and/or requests an oral hearing in person, an oral hearing by phone, or a review by written briefing;
- **e.** that, in the event of an oral hearing, the facility may appear in person with or without the assistance of counsel, may examine and cross-examine any witness under oath, and produce evidence on its behalf;
- **f.** that the truth of the allegations or failure to respond may result in sanctions including revocation; and
- **g.** that if the facility does not respond, or if the facility responds but does not dispute the allegations, comment on available sanctions, or request a review or hearing, then the facility waives its right to further review and appeal, and consents to the Review Committee rendering a final decision on the evidence before it and applying available sanctions.

iv. The Review Committee may offer the facility the opportunity to negotiate a specific sanction. Any agreed-upon sanction must be documented in writing and signed by ABRET and the facility.

D. Procedures of the Hearing Committee.

i. Written Review. If the facility requests a review by written briefing, the Review Committee will forward the allegations, the record of the investigation, the determination of a violation, the recommendation regarding sanction(s), and the response of the facility to the Hearing Committee. Written briefing may be submitted within thirty (30) days following receipt of the written review request by the Hearing Committee. The Hearing Committee will render a decision based on the record below and written briefs (if any) without an oral hearing.

ii. Oral Hearing. If the facility requests a hearing:

- **a.** The Review Committee will:
  - **(1)** forward the allegations, the record of the investigation, the determination of a violation, the recommendation regarding sanction(s), and the response of the facility to the Hearing Committee; and

(2) designate one of its members to present the allegations and any substantiating evidence, examine and cross-examine witnesses and otherwise present the matter during the hearing.

b. The Hearing Committee will:

(1) schedule a hearing after the request is received, allowing for an adequate period of time for preparation; and

(2) send by traceable delivery service, signature required, a Notice of Hearing to the facility. The Notice of Hearing will include a statement of the time and place selected by the Hearing Committee. The facility may request modification of the time and place for good cause. Failure to respond to the Notice of Hearing will be deemed to be the facility's consent for the Review Committee to administer any sanction which it considers appropriate.

c. The Hearing Committee will maintain a verbatim oral or written transcript.

d. ABRET and the facility may consult with and be represented by counsel, make opening statements, present documents and testimony, examine and cross-examine witnesses under oath, make closing statements and present written briefs as scheduled by the Hearing Committee.

e. The Hearing Committee shall determine all matters relating to the hearing.

f. Formal rules of evidence do not apply. Relevant evidence may be admitted. Disputed questions will be determined by the Hearing Committee.

g. The right to the hearing may be forfeited if the facility fails to appear without good cause.

iii. In all written reviews and oral hearings:

a. The Hearing Committee may accept, reject, or modify the recommendation of the Review Committee, either with respect to the determination of a violation or the recommended sanction.

b. Proof is by preponderance of the evidence.

c. The Hearing Committee will issue a written decision following the review or hearing and any briefing. The decision will contain factual findings, conclusions regarding ABRET's rules, and any sanctions applied. It will be mailed promptly by traceable delivery service, signature required, to the facility.

E. If the decision rendered by the Hearing Committee finds that the allegations are not established, no further action on the matter will occur.

F. If the decision rendered by the Hearing Committee is not favorable to the facility, the facility may appeal the decision to the ABRET Board of Directors.

G. Facilities submitting change notices and persons submitting complaints will be notified of the decision of the Hearing Committee.

10. Appeal to the Board of Directors.

A. A Director may not review any matter in which his/her impartiality might reasonably be questioned, or review any matter which presents an actual, apparent, or potential conflict of interest.

B. The facility may request an appeal within thirty (30) calendar days after its receipt of the Hearing Committee's decision. After this time, the facility may not request an appeal.

C. All appeals must be submitted in writing and sent to ABRET by traceable mail or delivery service.

D. The appeal must specify a valid basis for the appeal. If the President determines that the request is frivolous, then the appeal will not proceed.

E. The Review Committee may file a written response to the appeal request.

F. Written briefing may be submitted within thirty (30) days following receipt of the appeal request by the Board of Directors.

G. The Board of Directors will render a decision based on the record below and written briefs (if any) without an oral hearing. Alternatively, the Board of Directors may choose to conduct a new in-depth review of all the facts and rules (a "de novo" review). Only facts and conditions up to and including the time of the Hearing Committee's determination are considered during an appeal.

H. In all reviews:

i. In order to overturn a decision of the Hearing Committee, the facility must demonstrate that the Hearing Committee's decision was inappropriate because of (a) material errors of fact, or (b) failure to conform to ABRET's rules. Proof is by preponderance of the evidence.

ii. The Board of Directors may accept, reject, or modify the recommendation of the Hearing Committee, either with respect to the determination of a violation or the recommended sanction. The Board of Directors will issue a written decision following the review and any briefing. The decision will contain factual findings, conclusions regarding ABRET's rules, and any sanctions applied. It will be mailed promptly to the facility by traceable delivery service, signature required.

I. A decision rendered by the Board of Directors is final.

J. Facilities submitting appeals and persons submitting complaints will be notified of the decision of the Board of Directors.

11. Permanent Record. All decisions of the Hearing Committee and/or Board of Directors shall be filed as a part of a facility's accreditation record with ABRET.

12. Summary Procedure. If the Executive Director determines that there is cause to believe that a threat of immediate and irreparable harm to the public exists, the Executive Director shall forward the allegations to the ABRET Board of Directors. The Board shall review the matter immediately, and provide telephonic or other expedited notice and review procedure to the individual. If the Board determines (following this notice and opportunity to be heard) that

a threat of immediate and irreparable injury to the public exists, accreditation may be suspended for up to ninety (90) days pending a full review as provided herein.

13. Reinstatement of Eligibility. Following a period of ineligibility based on noncompliance with ABRET Standards, policies and procedures, the facility may apply for reinstatement of eligibility by demonstrating that it has taken corrective action. Unless and until clear and convincing evidence is submitted, the facility will remain ineligible.

14. Continuing Jurisdiction. ABRET may take action under this Policy during the time when a facility's application is pending and at any time during accreditation. In addition, ABRET retains jurisdiction to review and issue decisions regarding any matter which occurred prior to the expiration, or relinquishment of accreditation.