111 E. University Dr., Ste. 105–355
Denton, TX 76209
Phone/Fax: (217) 726-7980

LAB-LTM: Epilepsy Monitoring and Critical Care EEG Monitoring

ACCREDITATION APPLICATION

PART 1

I. Program Overview

Date Application Submitted:		
Hospital/Institution:		
Department Name:		
Address (include mail code or mail stop):		
City:	State:	Zip:
Name/Title Person Completing This Form:		
Phone:	E-mail Address:	

Is your EEG Laboratory an accredited **ABRET LAB-EEG**? Yes ☐ No ☐

Which LTM Accreditation are you applying for?	Epilepsy ☐	Critical Care ☐	Epilepsy w/invasive recordings ☐
Is your Pediatric program applying separately from your Adult program?	Yes ☐	No ☐	NA ☐
Are you currently accreditation through the National Accreditation of Epilepsy Centers (NAEC)?	Yes, Level: _____	No, but plan to apply ☐	No plans to apply for NAEC ☐

Epilepsy Monitoring ☐ Not applicable

Medical Director:	
Email:	Phone:
Technical Director (or equivalent):	
Email:	Phone:
Administrator/Title:	
Email:	Phone:

Pediatric Epilepsy Monitoring

☐ Same as Epilepsy Monitoring
☐ Not applicable

Medical Director :	
Email:	Phone:
Technical Director (or equivalent):	
Email:	Phone:
Administrator/Title:	
Email:	Phone:

Critical Care EEG

☐ Same as Epilepsy Monitoring
☐ Not applicable

Medical Director:	
Email:	Phone:
Technical Director (or equivalent):	
Email:	Phone:
Administrator/Title:	
Email:	Phone:

II. Volume

Indicate which types of procedures/patients you monitor and number of cases annually:

Type of procedure:	Yes	No	N/A	Number of procedures in the last year
Epilepsy Monitoring	☐	☐	☐	Total:
Diagnostic/Pre-surgical (scalp)	☐	☐	☐	Number:
Invasive extra-operative monitoring	☐	☐	☐	Number:
Have you performed at least 4 invasive recordings in the last 4 years?	☐	☐	☐	
Adult	☐	☐	☐	
Pediatric	☐	☐	☐	
Do you taper AEDs during admission?	☐	☐	☐	

Type of procedure:	Yes	No	N/A	Number of procedures in the last year
ICU/Critical Care EEG	☐	☐	☐	Total:
Adult	☐	☐	☐	
Pediatric	☐	☐	☐	
Neonates	☐	☐	☐	

Reminders:

1. Have you completed an Application Agreement Form (refer to Introduction & Standards form)? Yes ☐ No ☐
2. Is more than one facility applying for ABRET LAB-LTM Accreditation (i.e., satellite/partner facility, pediatric program separately from adult, etc.)? If so, please list the facilities that are applying:_____
   _____
   _____
3. Have you paid the processing fee ($100) yet or would you like to be invoiced for both the processing and accreditation fees (see ABRET website for details)?
   Yes ☐ No ☐

III. Personnel

Medical Director: complete CV form (Appendix 1)

Technical Director (or equivalent): complete CV form (Appendix 2)

Interpreting Physicians
List all the physicians involved with interpreting EEG data collected for Epilepsy and Critical Care EEG monitoring.

First and Last Name (add lines as necessary)	Degree(s)	Boards (select all that apply):				Participation in:	
		ABPN	ABPN: CNP / Epilepsy	ABCN: CNP / Epilepsy / CC-EEG / Pediatric EEG	Other	EMU	CC-EEG
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		☐	☐	☐		☐	☐

LTM Technologists

List all technologists participating in LTM:

First and Last Name (add lines as necessary)	Credentials (select all that apply):					Participation in:	
	R. EEG T. or R.E.T.	CLTM	NA-CLTM	CNIM	Not credentialed	EMU	CC-EEG
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IV. Signature Page

Information provided by:

_____ _____
Name (print) Signature

_____/_____/_____
Date

We have read the above application and the accompanying instructions manual. We verify that the information contained herein is accurate. Verified by:

1. Medical Director:

_____ _____
Name (print) Signature

_____/_____/_____
Date

2. Technical Director (or equivalent):

_____ _____
Name (print) Signature

_____/_____/_____
Date

3. Administrator: Signature or Letter of Support

_____ _____
Name (print) Signature

_____/_____/_____
Date

$100.00 is due with submission of the Part I Application

Contact Anna@abret.org if you require an invoice for processing. Pay online here or makes checks payable to ABRET LAB-LTM and mail to the:

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

Submit the Part I application, appendices, and application agreement by email to anna@abret.org or mail to:

ABRET Lab - LTM
c/o Anna M. Bonner
2054 Kildaire Farm Road #431
Cary, NC 27518

111 E. University Dr., Ste. 105–355
Denton, TX 76209
Phone/Fax: (217) 726-7980

LAB-LTM: Epilepsy Monitoring and Critical Care EEG Monitoring

PART 1
APPENDICES

Appendix 1
Curriculum Vitae

Medical Director

(If more than one Medical Director, complete CV Form for each)

Name:		
Degree(s):		
Medical School (name and location):		Year of Graduation:
Certification(s)		
American Board of Psychiatry and Neurology-Clinical Neurophysiology	YES ☐ NO ☐	Date: _____ Certificate number: _____ Expiration: _____
American Board of Clinical Neurophysiology	YES ☐ NO ☐	Date: _____ Certificate number: _____ Expiration: _____
Other board:	YES ☐ NO ☐	Date: _____ Certificate number: _____ Expiration: _____
Other board:	YES ☐ NO ☐	Date: _____ Certificate number: _____ Expiration: _____
Residency (type and location):		Date(s):
Fellowship (type and location):		Date(s):

Training in LTM (courses, conferences, workshops, etc.) over past five years:	Date(s):
Active State Licensure(s):	Expiration Date(s):
Current Academic Position(s):	Date Assumed this Position:
Current Hospital Appointments:	Date of Appointments:

In the space below list the most recent publications and presentations (maximum 10, not older than 5 years). Do not include abstracts, but those "in preparation", "submitted", and/or "in press" may be listed.

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Appendix 2

Curriculum Vitae

Technical Director

Name:		
Highest Degree:		
College/University (name, location):		Year of Graduation:
Credentials and certifications		
CPR/BLS	YES ☐ NO ☐	Date: _____ Certificate number: _____ Expiration: _____
ABRET R. EEG T. CBRET R.E.T.	YES ☐ NO ☐	Date: _____ Credential number: _____ Expiration: _____
ABRET R. EP T.	YES ☐ NO ☐	Date: _____ Credential number: _____ Expiration: _____
ABRET CNIM	YES ☐ NO ☐	Date: _____ Credential number: _____ Expiration: _____
ABRET CLTM	YES ☐ NO ☐	Date: _____ Credential number: _____ Expiration: _____
ABRET NA-CLTM	YES ☐ NO ☐	Date: _____ Credential number: _____ Expiration: _____
Other: _____	YES ☐ NO ☐	Date: _____ Credential number: _____ Expiration: _____

NDT/END Training Program (type and location):	Date(s):
Other NDT/END Education (type and location):	Date(s):
Training in LTM (description and location):	Date(s):

In the space below list the most recent continuing education credits earned in the field of EEG/LTM. Please do not include courses not related directly to EEG or LTM, such as sleep and CPR courses.

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