Fill out the form to log the required cases and submit with the application.

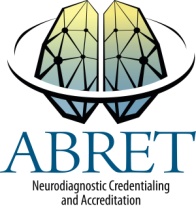
Twenty-five evoked cases encompassing three or more modalities, AEF, LEF, MEF, SEF, VEF

Fifty spontaneous cases

**CANDIDATE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **NO** | **Date of Recording/ Initials of Pt.** | **Type of Recording**  **Spontaneous or Evoked** | **Reading Physician** | **Indications for recording** | **Evoked Tasks Performed** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
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**Submit completed form with your application. Random auditing will be conducted by ABRET.**

***I certify that the information provided is true and accurate.***

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

***Signature of Medical Director or Supervisor* *Date***

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

***Print Name Clearly Phone # Email***

**CANDIDATE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **NO** | **Date of Recording/ Initials of Pt.** | **Type of Recording**  **Spontaneous or Evoked** | **Reading Physician** | **Indications for recording** | **Evoked Tasks Performed** |
| **17** |  |  |  |  |  |
| **18** |  |  |  |  |  |
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***Signature of Medical Director or Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***CANDIDATE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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| ***NO*** | ***Date of Recording/ Initials of Pt.*** | ***Type of Recording***  ***Spontaneous or Evoked*** | ***Reading Physician*** | ***Indications for recording*** | ***Evoked Tasks Performed*** |
| ***41*** |  |  |  |  |  |
| ***42*** |  |  |  |  |  |
| ***43*** |  |  |  |  |  |
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***Signature of Medical Director or Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***CANDIDATE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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| ***NO*** | ***Date of Recording/ Initials of Pt.*** | ***Type of Recording***  ***Spontaneous or Evoked*** | ***Reading Physician*** | ***Indications for recording*** | ***Evoked Tasks Performed*** |
| ***65*** |  |  |  |  |  |
| ***66*** |  |  |  |  |  |
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***Signature of Medical Director or Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***