2908 Greenbriar Dr., Ste. A, Springfield, IL 62704
Phone: (217) 726-7980 Fax: (217) 726-7989

LAB-LTM: Epilepsy Monitoring and Critical Care EEG Monitoring

ACCREDITATION APPLICATION

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 accredited **ABRET LAB-EEG**?	Yes ☐	No ☐
Are you applying for LTM Epilepsy Monitoring or Critical Care EEG Monitoring Accreditation or both?	Epilepsy ☐ With invasive recordings	Critical Care ☐

	☐	
Do you currently hold accreditation through The National Accreditation of Epilepsy Centers (NAEC)?	☐ Yes Current Level?	☐ No, but plan to apply ☐ No; no plans to apply for NAEC

Epilepsy Monitoring

☐ Not applicable

Medical Director:	
Phone:	E-mail Address:
Technical Director (or equivalent):	
Phone:	E-mail Address:
Administrator/Title:	
Phone:	E-mail Address:

Critical Care EEG

☐ Not applicable

Medical Director:	
Phone:	E-mail Address:
Technical Director (or equivalent):	
Phone:	E-mail Address:
Administrator/Title:	

Phone:	E-mail Address:

II. Volume

Indicate what types of procedures/patients you monitor

Type of procedures	Yes	No	N/A	Number of procedures in the last year	
Epilepsy Monitoring				Total:	
Diagnostic/Pre-surgical (scalp)				Number:	
Invasive extraoperative monitoring				Number:	Have you performed at least 24 invasive recordings in the last 4 years?
Adult					
Pediatric					
Do you taper AEDs during admission					
ICU/Critical Care EEG				Total:	
Adult					
Pediatric					
Neonates					

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.

Name(s) (add lines if necessary)	Degree/s	Boards	Participation in:	
		☐ ABPN ☐ ABCN ☐ ABPN-CNP ☐ Other	EMU ☐	Critical Care EEG ☐
		☐ ABPN ☐ ABCN ☐ ABPN-CNP ☐ Other	EMU ☐	Critical Care EEG ☐
		☐ ABPN ☐ ABCN ☐ ABPN-CNP ☐ Other	EMU ☐	Critical Care EEG ☐
		☐ ABPN ☐ ABCN ☐ ABPN-CNP ☐ Other	EMU ☐	Critical Care EEG ☐
		☐ ABPN ☐ ABCN ☐ ABPN-CNP ☐ Other	EMU ☐	Critical Care EEG ☐
		☐ ABPN ☐ ABCN ☐ ABPN-CNP ☐ Other	EMU ☐	Critical Care EEG ☐

LTM Monitoring Technologist

List all technologists participating in LTM

Name(s) (add lines if necessary)	Registration	Participation in:	
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐
	☐ CLTM ☐ R. EEG T./R.E.T. ☐ CNIM ☐ Unregistered	EMU ☐	ICU ☐

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:

_____	_____	_____
Name (print)	Signature	Date

3. Administrator: Signature or Letter of Support

_____	_____	_____
Name (print)	Signature	Date

$75.00 is due with submission of the Part I Application

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LAB-LTM

APPENDICES

Appendix 1
Curriculum Vitae

Medical Director

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):
Name:		

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, and those "in preparation" or "submitted." Articles "in press" may be listed.

Appendix

Curriculum Vitae(s)

Technical Director

Name:		
Highest Degree:		
College (name, location):		Year of Graduation:
Certification(s)		
CPR	YES ☐ NO ☐	Date: Certificate number: Expiration:
ABRET R. EEG T. CBRET R.E.T.	YES ☐ NO ☐	Date: Certificate number: Expiration:
ABRET R. EP T.	YES ☐ NO ☐	Date: Certificate number: Expiration:

ABRET CNIM	YES ☐ NO ☐	Date: Certificate number: Expiration:
ABRET CLTM	YES ☐ NO ☐	Date: Certificate number: Expiration:
Other:	YES ☐ NO ☐	Date: Certificate number: Expiration:

Name:	
END Training Program (type and location):	Date(s):
Other 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.