



## Certification Examination for Autonomic Professionals Technologists – (CAP) Application Form

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Please read the directions in the HANDBOOK for CANDIDATES carefully before completing this Application.

Name (exactly as it appears on a Government Issued Photo I.D.):

Address:

City:

State:

Zip:

Country:

Telephone Number:

Date of Birth (mm/dd/yyyy):

Email Address:

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### **ELIGIBILITY**

- CAP Pathway I – Associate Degree or Higher** (Provide documentation for degree, 20 autonomic cases, 3 educational activities and current CPR/BLS)
- CAP Pathway II – Employed in Autonomics** (40 autonomic cases, 3 educational activities and current CPR/BLS)

Please provide supervisor contact information for validation of your years of experience in electroneurodiagnostics.

Name:

Telephone Number:

Email Address:

or applying for  **Recertification** of current CAP

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### **BACKGROUND**

Years of experience in Autonomic Testing:

- |                                    |  |
|------------------------------------|--|
| <input type="radio"/> 1 year       | <input type="radio"/> 6 to 10 years      |
| <input type="radio"/> 2 to 3 years | <input type="radio"/> More than 10 years |
| <input type="radio"/> 4 to 5 years |  |



### CAP Application Form - Continued

Highest Academic Level Attained:

- |  |                                       |
|--|---------------------------------------|
| <input type="radio"/> GED or equivalent                            | <input type="radio"/> Master's Degree |
| <input type="radio"/> High School Graduate                         | <input type="radio"/> Doctorate       |
| <input type="radio"/> Vo-tech School Graduate or Associates Degree | <input type="radio"/> Other           |
| <input type="radio"/> Bachelor's Degree                            |                                       |

Autonomic Examinations Recorded:

- |                                |                                     |
|--------------------------------|-------------------------------------|
| <input type="radio"/> 20       | <input type="radio"/> 61 to 100     |
| <input type="radio"/> 21 to 40 | <input type="radio"/> More than 100 |
| <input type="radio"/> 41 to 60 |                                     |

Percent of working time currently spent in Autonomic Testing:

- |                                     |                                  |                                     |
|-------------------------------------|----------------------------------|-------------------------------------|
| <input type="radio"/> Less than 25% | <input type="radio"/> 25% to 75% | <input type="radio"/> More than 75% |
|-------------------------------------|----------------------------------|-------------------------------------|

Educational activities related to autonomics within the last 3 years:

- |   |                                    |
|---|------------------------------------|
| <input type="radio"/> 3 activities      | <input type="radio"/> 7 to 10      |
| <input type="radio"/> 4 to 6 activities | <input type="radio"/> More than 10 |

Procedures in Autonomic Reflex Screen (ARS) or Autonomic Function Test (AFT) you personally performed:

- |  |   |
|--|---|
| <input type="checkbox"/> Quantitative Sudomotor Axon Reflex Test (QSART) | <input type="checkbox"/> Head-up Tilt   |
| <input type="checkbox"/> Valsalva Maneuver                               | <input type="checkbox"/> Deep Breathing |
| <input type="checkbox"/> Other: _____                                    |   |

Procedures in Reflex Sympathetic Dystrophy Screen you personally performed:

- |  |   |
|--|---|
| <input type="checkbox"/> Quantitative Sudomotor Axon Reflex Test (QSART) | <input type="checkbox"/> Resting Sweat Output (RSO) |
| <input type="checkbox"/> Thermoregulatory Sweat Test (TST)               | <input type="checkbox"/> Resting Skin Temperatures  |
| <input type="checkbox"/> Other: _____                                    |   |

Healthcare Credentials you have earned:

- |   |                                    |
|---|------------------------------------|
| <input type="checkbox"/> R. EEG T.      | <input type="checkbox"/> CNIM      |
| <input type="checkbox"/> CLTM           | <input type="checkbox"/> R. PSG T. |
| <input type="checkbox"/> R. NCS T./CNCT | <input type="checkbox"/> RN        |
| <input type="checkbox"/> R. EP T.       |                                    |

Other:



## CAP Application Form - Continued

Primary reason for taking examination:

- |  |  |
|--|--|
| <input type="radio"/> Job requirement          | <input type="radio"/> Professional advancement |
| <input type="radio"/> Salary increase          | <input type="radio"/> Personal goal            |
| <input type="radio"/> Job security             | <input type="radio"/> School requirement       |
| <input type="radio"/> Competency demonstration | <input type="radio"/> Other                    |

Have you taken this examination before?  Yes  No

If Yes, indicate what month/year:

If Yes, under what name was the exam taken:

### Eligibility Questions

Please indicate your answers to the following questions. If you answer yes to ANY question, you must submit a letter of explanation. In your letter, please indicate whether you have reported the information on a previous application. ABRET will review this information and determine whether you are eligible for certification. During this review, your application will be kept on hold:

Have you ever been found to have committed negligence or malpractice related to your professional work?

- Yes  No

Is a disciplinary review pending against you before a governmental regulatory board of a professional organization other than ABRET?

- Yes  No

Are there any criminal charges pending against you?

- Yes  No

Have you ever been convicted of a crime? This includes (but not limited to) rape, sexual abuse of a patient or child, actual or threatened use of a weapon or violence, and prohibited sale, distribution, or possession of a controlled substance.

- Yes  No



## CAP Application Form - Continued

### Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your test results.

Race:

- African American
- Asian
- Hispanic
- Native American
- White
- Other

Age Range:

- Under 25
- 25 to 29
- 30 to 39
- 40 to 49
- 50 to 59
- 60+

Gender:

- Male
- Female

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## COMPLETE ENTIRE APPLICATION BEFORE CONFIRMATION BELOW

### Application Agreement

I certify that all the information contained in my application is true and complete to the best of my knowledge. I hereby authorize the American Board of Registration of Electroencephalographic and Evoked Potential Technologists and its officers, directors, employees, and agents (collectively, "ABRET") to review my application and to determine my eligibility for certification.

I have read and agree to be in compliance with the ABRET Rules including but not limited to those listed in the *Certification for Autonomic Professionals Handbook for Candidates*.

\* I acknowledge that I have read the full content of the Application Agreement provided in the *Certification for Autonomic Professionals Handbook for Candidates*. I understand this Application Agreement and agree to its terms in consideration for the opportunity to seek certification from ABRET. If not, please contact the ABRET office at (217) 726-7980.

"I Agree"

\* I have read the *Certification for Autonomic Professionals Handbook for Candidates* and understand that I am responsible for knowing its contents.

"I Agree"

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Signature

(Date)



**CAP Application Form - Continued**

**PAYMENT**

Please note that when you submit this form you are required to submit the **\$400 CAP exam payment** along with the **\$50 manual application processing fee**. Total amount **\$450**

Please indicate Payment Type:

- Check
- Money Order
- Visa
- MasterCard

If payment is by credit card, please complete the following:

Name (as it appears on card):

Address (as it appears on billing statement):

City:

State:

Zip:

Country:

Card #:

CVV:

Expiration Date:

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Signature

(Date)

\*\*\*NOTE\*\*\*

All candidates must provide proof of hands-on CPR/BLS training. **A copy of your current CPR card and official documentation must accompany the Application along with payment.**

Please submit your application along with any additional required documentation to the ABRET office.

Candidates will have 3 months to take their exam. If they do not test there is no refund or transfers.

**ABRET Executive Office  
111 E. University Dr. #105-355  
Denton, TX 76209  
Phone/FAX (217) 726-7980**