

**The American Board of Pediatric Neurological Surgery**

Application for the ABPNS Pediatric Written Focused Practice Examination

Requirements:

1. **Purchase Exam (available approximately 1 week before exam date)**
2. **Register and schedule time slot for assigned exam day.**
3. **Complete pre-exam requirements, including equipment self-check.**

**Please read carefully and check the appropriate boxes (double left click and then choose “checked”. Application will not be processed until complete.**

**Part I: Contact and Practice Information**

**Name:**

**Office Address:**

**Institution:**

**Street:**

**City: State or Province:**

**Zip Code: Country:**

**Home Address:**

**Preferred Mailing Address: □Home □Office**

**Phone:**

**Home/Cell:**

**Fax:**

**E-mail:**

**Fellowship:**

**Institution:**

**ACPNF-accredited slot? (Y/N)**

**Dates of Training:**

**Director:**

**Residency Program:**

**Institution:**

**Dates of Training:**

**Medical School:**

**Institution:**

**Dates of training:**

**Licensure Information**

**STATE OR PROVINCE LICENSE NUMBER RESTRICTED OR SUSPENDED**

**­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **Yes**  **No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **Yes**  **No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **Yes**  **No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **Yes**   **No**

**Supporting documentation accompanying this application. Please check off:**

Proof of Residence in U.S. or Canada. (Can be a copy of a driver’s license).

Letter of good standing from fellowship director or copy of fellowship certificate.

Copy of Residency certificate.

Copy of Medical License.

Copy of Royal College of Physicians and Surgeons of Canada (RCPS-C) certificate if applicable.

Please submit this application and the supporting documentation listed above via e-mail to kbollerman@abns.org.

By signing below, I hereby verify that all information submitted here is true and accurate, and has been

completed to the best of my knowledge.

Electronically signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type in your name to verify above)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABPNS Administrative Area only:

□ Verify participation in an ACPNF approved fellowship in the ACPNF slot.

□ Is the applicant following the ABNS or RC track? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_