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 Identification (driver's license or passport)
☐ 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? _____