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

<table>
<thead>
<tr>
<th>STATE OR PROVINCE</th>
<th>LICENSE NUMBER</th>
<th>RESTRICTED OR SUSPENDED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

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? ___________________________