**American Audiology Board of Intraoperative Monitoring**

**MEMBER APPLICATION FORM**

Please complete all sections of the application. Attach a separate sheet, if additional documentation is necessary. Identify name of applicant on all submitted sheets.

*Note: Audiologists with current D.ABNM status acquired prior to April 1, 2013 are exempt from the written exam requirement. Please provide documentation of CCC-A and D.ABNM credentials with the completed application.*

**Section I: BACKGROUND INFORMATION**

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| --- | --- | --- | --- |
| NAME |       | CREDENTIALS |       |
| APPLICATION DATE  |       | PROFESSIONAL TITLE |       |
| ASHA MEMBER # |       | CCC ISSUED (MO/YR) |       |
| STREET ADDRESS |       | APT# |       |
| CITY |       | STATE/PROVINCE |       |
| ZIP/POSTAL CODE |       | ABOVE ADDRESS IS: | [ ] Work [ ] Home |
| EMAIL |       | PHONE: [ ] C [ ] W [ ] H |       |
| BIRTH DATE |       | SEX:[ ]  M [ ]  F | LOCATION OF BIRTH |       |
| US CITIZEN | [ ]  YES [ ]  NO |
| EMPLOYER |       |
| EMPLOYER ADDRESS |       |
| CITY,  |       | STATE/PROVINCEZip/Postal Code |       |

**Section II. EDUCATION, CERTIFICATION AND/OR LICENSING**

APPLICANT NAME:

|  |
| --- |
| **DEGREES AWARDED: List Most Recent First** |
| **Degree Awarded****(Include Area of Study)** | **Date Received** | **Institution (Include Address)** | **Date of****Transcript Request** |
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**Section II. EDUCATION, CERTIFICATION AND/OR LICENSING**

(Continued)

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| **CERTIFICATIONS AND LICENSING****(Attached Copies or email PDF Copies of Each Certificate or License)** |
| **Type** | **Number** | **Organization** | **Year Awarded** |
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APPLICANT NAME:

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| **CONTINUING EDUCATION UNITS** |
| **Date(s)** | **Provider** | **Name, Location (or type) of Meeting or Course** | **Hours Earned** |
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**Section III. EXPERIENCE**

APPLICANT NAME:

|  |  |  |  |
| --- | --- | --- | --- |
| ***ABBREVIATION*** | **FULL NAME** | **CITY** | **STATE** |
| *RMC* | *Regional Medical Center* | *Example* | *EX* |
|       |       |       |       |
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**LOCATION(S**): Enter the full name, city and state of each hospital, medical center or outpatient facility where cases listed on the CASE LOG were completed. Use the abbreviation you assigned to the left to indicate “Location” on the CASE LOG.

|  |  |  |  |
| --- | --- | --- | --- |
| **LAST NAME** | **FULL NAME** | **CITY** | **STATE** |
| *Smith* | *John Smith, M.D.* | *Example* | *EX* |
|       |       |       |       |
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**SURGEON(S):** Enter the full name, city and state of practice for the primary surgeon **OR** on-site supervisor for cases listed on the Case Log. Use the last name to indicate the “Surgeon” on the Case/Patient Log.

(If there is more than one surgeon with the same last name and first initial (e.g. Last, F)

**Section III: EXPERIENCE**

(Continued)

APPLICANT NAME:

**SUPERVISOR(S)/EMPLOYER:** Enter the full name and employer of supervisor. You must include a CV for the supervisor(s) demonstrating three (3) consecutive years experience as a provider of Neurophysiologic Intraoperative Monitoring Services (IOM), a list of current locations as a provider of NIOM services, and verification of any certification in NIOM (e.g. CNIM, DABNM).

|  |  |  |  |
| --- | --- | --- | --- |
| **LAST NAME** | **FULL NAME** | **EMPLOYER** | **CONTACT EMAIL FOR EMPLOYMENT VERIFICATION** |
| **Jones** | **Jane Jones** | **Regional Medical Center** | **jane.jones@rmc.org** |
|       |       |       |       |
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**Section IV. CASE/PATIENT LOG**

APPLICANT NAME:

Attach additional sheets as necessary. Page Number:

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Case #** | **Date** | **Location (Abbreviate)** | **Supervisor** | **Surgeon/****Physician** | **Surgical Case****(Choose one per case)** | **Outpatient** | **Modality****( Indicate all used)** |
| Scoliosis/T-Spine | Cervical Spine | Lumbar Spine | Spine Tumor | Vascular | Brain Tumor | SSEP | ABR | TcMEP | EMG | EEG | Other |
|       |       |       |       |       | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
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**Section V: ATTESTATIONS**

**SUPERVISOR**

APPLICANT NAME:

SUPERVISOR NAME:

I have reviewed the applicant’s case log. My signature below verifies that the above named applicant was supervised by me and was present and involved in providing neurophysiologic Intraoperative monitoring care for all cases where I am listed as the supervisor on the NIOM CASE LOG. I have provided my CV which demonstrates three consecutive years experience as a provider of NIOM, a list of locations where I currently provide NIOM, my educational qualifications, and verification of any professional board certification or scope of practice statements in NIOM (e.g., DABNM, ASHA Scope of Practice in NIOM, 1991)) attesting to my ability to serve in the role of supervisor, clinical mentor and primary interpreting provider.

Signature of Supervisor:

Date of Signature:

\*Use as many copies of this page as necessary.

**Section V: ATTESTATIONS**

**SURGEON**

APPLICANT NAME:

SURGEON NAME:

I have reviewed the applicant’s case log. My signature below verifies that the above named applicant was present and involved in providing neurophysiologic intraoperative monitoring care of my surgical patients during those procedures listed with me as the primary operating surgeon. I hereby attest to the clinical competencies of the above-named audiologist in the acquisition and interpretation of intraoperative neurophysiological monitoring data for the listed surgical cases.

Signature of Primary Surgeon:

Date of Signature:

\*Use as many copies of this page as necessary.

**Section VI: ADVERSE EXPERIENCES**

APPLICANT NAME:

1. Have you ever had your professional license to practice suspended, revoked or subjected to reprimand?

      Yes       No

1. Have you ever voluntarily surrendered your professional license to practice under any circumstances other than expiration?

     Yes       No

1. Have you ever been subject to disciplinary action by a hospital, State Medical Board, ASHA, or other medical professional organization?

      Yes       No

1. Have you ever been convicted of a misdemeanor or felony?

     Yes       No

1. I fully understand that the American Audiology Board of Intraoperative Monitoring (AABIOM), its authorized staff, and their representatives may validate my professional credentials by consulting with the American Speech Language and Hearing Association and/or State Audiology Board or other nationally recognized bodies that maintain automated data files on clinical care professionals.

      Yes      No

1. I certify that the statements/documentation that I have made/provided in this application packet are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that an incorrect or incomplete statement could void continued processing of my application.

Signature of Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      \_

**Section VI: PAYMENT INFORMATION AND SUBMISSION**

APPLICANT NAME:

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| --- |
| **PAYMENT METHOD** |
| CREDIT CARD | [ ]  VISA [ ]  MASTERCARD [ ]  DISCOVER  |
| CARD NUMBER |       | EXPIRATION DATE (MM/YY)CVV #(3 digits) |       |
| NAME AS IT APPEARS ON CREDIT CARD |       |
| ADDRESS AS IT APPEARS ON STATEMENT |       |
| AUTHORIZING SIGNATURE |       |
| OTHER PAYMENT | 🞎 CHECK ENCLOSED | CHECK # |       |

1. Submit non-refundable $75.00 application fee, payable to “American Audiology Board of Intraoperative Monitoring (AABIOM)”. ($800 examination fee to be submitted upon scheduling of written examination).

Or

If applying under the grandfathering of D.ABNM holders, submit nonrefundable $350.00 application fee, payable to “American Audiology Board of Intraoperative Monitoring (AABIOM)”.

1. Send one copy of your completed application to:

American Audiology Board of Intraoperative Monitoring

2815 Camino Del Rio South, Suite 220

San Diego, CA 92108

Office phone: 858-279-6772 ext 4

Email: AABIOM@neurodynamicsinc.org