**American Audiology Board of Intraoperative Monitoring**

**RENEWAL 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.

**The BCS-IOM renewal process requires:**

* Submission of proof of current ASHA membership.
* Case log documentation of a minimum of 150 cases performed within the 5 year period.
* 10 CEUs over the 5 year renewal period in the area of specialty certification and document evidence of intermediate or advanced continuing education *(NOTE: 0.1 CEU=1 clock hour)\**
* $350.00 Renewal Fee

**Section I: BACKGROUND INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| NAME |  | | CREDENTIALS | |  | |
| PROFESSIONAL TITLE | |  |
| STREET ADDRESS |  | |
| CITY |  | | STATE/PROVINCE | |  | |
| ZIP/POSTAL CODE |  | | ABOVE ADDRESS IS: | | Work Home | |
| EMAIL |  | | PHONE: C W H | |  | |
| EMPLOYER |  | | | | | |
| EMPLOYER ADDRESS |  | | | | | |
| CITY, |  | | | STATE/PROVINCE  Zip/Postal Code | |  |

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

(Continued)

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| **CERTIFICATIONS AND LICENSING**  **(Attached copy of current ASHA membership card)** | | |
| **ASHA Number** | **Year Awarded** | **Year Expires** |
|  |  |  |

APPLICANT NAME:

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| **CONTINUING EDUCATION UNITS**  10 CEUs over the 5 year renewal period in the area of specialty certification and document evidence of intermediate or advanced continuing education (NOTE: 0.1 CEU=1 clock hour)\*  \* Due to changes that went into effect January 1, 2014, BCS-IOM inaugural members who became certified September, 2012, will have the CEU maintenance requirements reduced from 100 contact hours to 60 contact hours for this first 5 year renewal period. All subsequent 5 year renewal cycles will be subject to the standard Maintenance and Renewal requirements. | | | |
| **Date(s)** | **Provider** | **Name, Location (or type) of Meeting or Course** | **Hours Earned** |
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**Section III. EXPERIENCE**

APPLICANT NAME:

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| ***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. 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 IV. CASE/PATIENT LOG**

APPLICANT NAME:

Attach additional sheets as necessary. Page Number:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Case #** | **Date** | **Location (Abbreviate)** | **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 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 $350.00 renewal fee, payable to “American Audiology Board of Intraoperative Monitoring (AABIOM)”.
2. Send one copy of your completed application to:

American Audiology Board of Intraoperative Monitoring

563 Carter Court, Suite B

Kimberly, WI 54136

Office phone: 920-560-5631

Fax 920-882-3655

Email: [karen@badgerbay.co](mailto:karen@badgerbay.co)