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 <u>all</u> 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)

APPLICANT NAME: _____

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

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

Section III. EXPERIENCE

APPLICANT NAME: _____

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.

ABBREVIATION	**FULL NAME**	**CITY**	**STATE**
RMC	*Regional Medical Center*	*Example*	*EX*

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)

LAST NAME	**FULL NAME**	**CITY**	**STATE**
Smith	*John Smith, M.D.*	*Example*	*EX*

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
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Section VI: ADVERSE EXPERIENCES

APPLICANT NAME: _____

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

   _____ Yes _____ No

2. Have you ever voluntarily surrendered your professional license to practice under any circumstances other than expiration?
   _____Yes _____ No

3. Have you ever been subject to disciplinary action by a hospital, State Medical Board, ASHA, or other medical professional organization?
   _____ Yes _____ No

4. Have you ever been convicted of a misdemeanor or felony?
   _____Yes _____ No

5. 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

6. 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: _____

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
2815 Camino Del Rio South, Suite 220
San Diego, CA 92108
Office phone: 858-279-6772 ext 4
Email: AABIOM@neurodynamicsinc.org