Fill out the form to log your required clinical EP studies (25), have supervisor sign, and upload to Credential Manager.

Cases must have been recorded within the last 5 years by the applicant, with 10 being recorded within the last 12 months.

Cases performed in the Operating Room may not be counted.

 **CANDIDATE NAME:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NO** | **Date of Recording/ Initials of Pt.** | **Hospital/Clinic Office name & phone number** | **Modality Recorded** | **Reading Physician** | **Indications for recording** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
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![new_abret_logo[1] (2)]()

***I certify that the information provided is true and accurate. Submit completed form with your application.***

***Random auditing will be conducted by ABRET.***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\*\*All form pages must be signed\*\*\****

***Signature of Medical Director or Supervisor* *Date***

 ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ page \_\_\_\_ of \_\_\_\_***

 ***Print Name Clearly Phone # Email***

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 **CANDIDATE NAME:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NO** | **Date of Recording/ Initials of Pt.** | **Hospital/Clinic Office name & phone number** | **Modality Recorded** | **Reading Physician** | **Indications for recording** |
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| **21** |  |  |  |  |  |
| **22** |  |  |  |  |  |
| **23** |  |  |  |  |  |
| **24** |  |  |  |  |  |
| **25** |  |  |  |  |  |
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![new_abret_logo[1] (2)]()

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***Signature of Medical Director or Supervisor* *Date***

 ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ page \_\_\_\_ of \_\_\_\_***

 ***Print Name Clearly Phone # Email***