## CNIM® DOCUMENTATION FORM

***Fill out the form completely. Indicate hospital name and phone number of OR scheduling office or hospital office for verification of cases. You only need to write information down once. If more than one hospital, indicate as hospital #1, #2, etc.***

***Candidate must be present and an active participant in the set-up and monitoring of each case. ABRET will accept up to two cases per day.***

**CANDIDATE NAME:**

| NO | DATE Of PROCEDURE | HOSPITAL NAME/ PHONE NUMBER | PRIMARY SURGEON | TYPE OF SURGERY | TIME IN/ OUT OF ROOM | MODALITY (IES) MONITORED |
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***I certify that the information provided is true and accurate on all pages to be submitted.***

***Submit completed form with your application. Random auditing will be conducted by ABRET.***

_____

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

***page ____ of ____***

_____

***Print Name Clearly Phone #***

***12/09***

ABRET