**Subspecialty Practice Time Verification**

(Two letters of verification required)

**Instructions:**

1. **COPY TEMPLATE TEXT BELOW TO INSTITUTION LETTERHEAD.**
   * Letters that are not on proper letterhead will not be accepted
2. Complete all information in sections 1 – 4.
3. Sign the letter using a handwritten signature, digitized signature, or electronic signature equivalent: /John Doe/
4. Applicant uploads the completed letter into their online certification application.
5. Questions? Contact Becky Swanson, Operations and Executive Office Manager at [bswanson@ucns.org](mailto:bswanson@ucns.org) or  
   (612) 928-6050.

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<Insert Date>

Dear UCNS Certification Department:

This letter serves as documentation of subspecialty practice time for the individual listed below:

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| 1. Applicant name and credentials: |
| 2. Number of years familiar with the applicant’s practice pattern: |
| 3a. **For Interventional Neurology and Neurocritical Care Only** (check one)  At least 25% of the applicant’s practice time during a 48-month period or  At least 33% of the applicant’s practice time during a 36-month period or  At least 50% of the applicant’s practice time during a 24-month period has been devoted to the subspecialty and has occurred in the 60-month interval immediately preceding the application deadline for certification but need not be continuous. |
| 3b. **For Neonatal Neurocritical Care Only** (check one)  At least 25% of the applicant’s practice time during a 36-month period or  At least 50% of the applicant’s practice time during a 24-month period has been devoted to the subspecialty and has occurred in the 60-month interval immediately preceding the application deadline for certification but need not be continuous. |
| 3c. **For all other subspecialties** At least 25% of the applicant’s practice during a 36-month period has been devoted to the subspecialty and has occurred in the 60-month interval immediately preceding application deadline for certification but need not be continuous.  Yes  No |
| 4. Subspecialty:  Autonomic Disorders  Behavioral Neurology & Neuropsychiatry  Clinical Neuromuscular Pathology  Headache Medicine  Interventional Neurology  Neonatal Neurocritical Care  Neurocritical Care  Neuroimaging  Neuro-oncology |

Sincerely,

<Insert signature, see #3 of instructions above>

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| --- |
| Name and credentials: |
| Name of institution: |
| Address: |
| Phone number: |
| Email: |