



# **American Board of Pediatric Neuropsychology AAPdN**

## **Application for Board Certification**

## *Eligibility*

The American Board of Pediatric Neuropsychology (AAPdN) appreciates that clinicians developed pediatric specific expertise by different paths. The goal of the board is to verify competence, and to do so through an examination process that balances ecological validity, rigor, and flexibility. All candidates complete a credential review and examination. AAPdN does not offer “grandfathering” and/or senior options for the credentialing process.

For US and Canadian clinicians, the standard requirements for application are outlined below. International applicant materials will be reviewed for equivalence.

1. Completion of a doctoral degree in psychology (EdD, PsyD or PhD).<sup>1</sup>
2. An organized training experience in the neurosciences, pediatrics, assessment, rehabilitation, and psychopathology of no less than 2 years. Workshops and weekend conferences cannot meet this requirement.
3. Ideally, this is met through an APPIC or APA approved internship that includes a 50% concentration in neuropsychology, followed by two-year post-doctoral supervised experience, at least 50% of which is pediatric oriented.<sup>2</sup>
4. Licensure or certification at the independent practice (doctoral) level, as a Psychologist, in the state, province, or territory in which the clinician practices. Psychologists who have retired from active practice are welcomed under the *emeritus status*, if they otherwise meet the credentials requirements and successfully complete the examination process.

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<sup>1</sup> Specifically, a degree from a regionally accredited program in applied psychology that was, at the time the degree was granted, accredited by the APA, CPA or was listed in the publication *Doctoral Psychology Programs Meeting Designation Criteria (ASPPB National Register designation committee)*.

Membership in the *National Register of Health Service Providers in Psychology*, the *Canadian Register of Health Service Providers*, or those holding the *Certificate of Professional Qualification* qualify as meeting the doctoral requirements for membership provided that the degree was not granted from an online institution and that the residency requirements conform to APA CoA standards

(<http://www.apa.org/ed/accreditation/about/policies/doctoral-instructions-2011.pdf>).

<sup>2</sup> While we support many of the goals of the Houston Conference model, we appreciate that applicants might meet those aspirational standards while lacking substantial pediatric training. We also appreciate that the match system and the limited number of pediatric specific training sites may force candidates to seek alternative, comparable training.

## ***The Examination Process***

The examination includes four steps: The review of credentials, review of a work sample, a written examination and an oral examination.

1. We review your completed application and decide whether it demonstrates that you meet the minimal education, training, and experience criteria for board eligibility;
2. If you are determined to be board-eligible, you will be invited to provide a practice samples that reflects your *typical* work as a pediatric neuropsychologist. This sample must be recent and completed independently (e.g., We cannot accept samples used as part of post-doctoral training experience.) Please send work samples completed during the past 24 months. We ask that work samples be submitted *no later than 30 days before the date of the combination written/oral examination* (see below).

Two examiners review your work sample based on an established scoring rubric. The work sample is acceptable if it receives a passing score by two examiners. If one of the two examiners finds the sample inadequate, the sample is reviewed by another examiner (who is unaware that they are the third examiner.) If the sample is again found lacking, then the candidate is informed of the weaknesses, provided with an opportunity for direction, and offered the opportunity to submit a new sample.

3. The single day written and oral examination is offered at the annual *National Academy of Neuropsychology* meeting (NAN) and may be offered at other meetings. ABPdN offers regional examinations depending on demand and examiner availability. The written portion of the examination *may* be proctored locally.
4. The *written examination* is comprised of 100 questions, plus additional questions in development that will not count toward the final score. The exam topics include basic sciences, pediatric neurosciences, neuropsychological application, and the application research methods and test construction to clinical work. The items are not reflective of any particular theoretical orientation. A candidate who passes 70% of the items has successfully completed this portion of the examination process. Candidates who do not meet this threshold are allowed to retake the written examination at its next administration.
5. The *oral and written examination* portions may be offered during the same week. Completion of the oral examination is not predicated on successful passage of the written examination. These steps can be concurrent. If English is not your preferred language, please notify us. When available, we will try to include at least one bilingual examiner.

The *oral examination process* is intended to be a collegial, but rigorous review of a candidate's integration of neuropsychological knowledge with their current practice, including a firm understanding of the ethical issues and obligations. The candidate meets with three examiners, each of whom is a board certified pediatric neuropsychologist selected from a panel of trained examiners. A fourth "examiner in training" may audit the examination. The examiners independently score the candidate on a standard rubric prior to discussing on the case.

The *oral examination* is organized in three parts:

- An interview surveying the candidate's current practice and conceptual frame.
- A review of the work sample and the candidate's analysis and integration of the findings, including topics such as the relevant pathophysiology or the pragmatic implications for a child's functioning at home and at school.
- The presentation of two vignettes. The candidate chooses one, reviews the material, and provides an assessment of the case and any relevant ethical or legal concerns.

The *interview* allows the examiners have a better understanding of the professional context for the work sample and depth of the candidate's neuropsychological training. The *review of the work sample* is intended to be a collegial opportunity for the reviewers to verify the candidate's preparation and readiness for board certification. Candidates are given the opportunity to demonstrate the blend of professional practice with general and pediatric specific knowledge (e.g., neuroscience and neuropsychology, neurodevelopment, pediatric specific illnesses, and legal and ethical issues unique to children).

The Examination Chair, currently Dr. Peter Dodzik, will notify candidates of their results and may offer specific feedback on strengths and weaknesses noted by the examiner. Many candidates report finding the entire process constructive, highlighting where skills may have become rusty or knowledge out of date. The opportunity for such intensive work review with board-certified pediatric colleagues often serves as its own impetus for professional self-development.

*A candidate failing one or more sections of the exam*, may retake the examination one time without additional charge, and will be provided with feedback to assist in directing their studies and preparation for the next exam.

*When a candidate has successfully passed all four stages of the examination process*, the Examination Chair notifies the candidate and issues the diploma. The candidate is then fully board certified and inducted as a Fellow of the American Academy of Pediatric Neuropsychology (AAPdN) with all of the rights and privileges this entails. At this point, you may identify yourself as a Diplomate or Fellow of the Academy and as board certified by the American Board of Pediatric Neuropsychology.



***American Board of Pediatric Neuropsychology  
Application***

PLEASE PRINT OR TYPE ONLY

**Please submit completed application and current copies of:** (Please mark “X” when complete)

1. Copies of all Current State Professional Licenses \_\_\_\_\_
2. Malpractice Insurance Certificate(s) \_\_\_\_\_
3. Complete Typed Responses to Clinical Vignettes Provided with Application \_\_\_\_\_
4. Official copies of all Transcripts for Undergraduate and Graduate Degrees submitted to the address below \_\_\_\_\_
5. Evidence of National Register or CPQ or other license verifying membership (if applicable) \_\_\_\_\_
6. A copy of your Current Curriculum Vita \_\_\_\_\_
7. Copies of any Current Board Certifications from ABPP board or ABPN (if applicable) \_\_\_\_\_
8. Complete Neuropsychologically Related Work History since Graduation \_\_\_\_\_
9. Breakdown of your patients’ demographics over past 5 years as described at the end of this application. \_\_\_\_\_
10. **On a separate sheet**, please describe your practice of Pediatric Neuropsychology for the last 5 years \_\_\_\_\_
11. **On a separate sheet**, list the names of the tests you regularly administer and are comfortable with \_\_\_\_\_

**Please mail THREE (3) copies of this application to:**

**Dr. Peter Dodzik, PsyD, ABPdN, ABN  
415 West Golf Road, Suite 16  
Arlington Heights, IL 60005**

*Please completely answer all sections and if the existing space is insufficient, or if a section is not answered completely, attach information/explanation and reference the section/question.*

***Personal Data***

Name (First, MI, Last): \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_

Business Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name(s) by which you were licensed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Degree Type: (Circle one)                      PhD                      PsyD                      Ed

Social Security Number:                      -                      -                      \_\_\_\_\_

Date of Birth:                      /                      /                      \_\_\_\_\_

Birthplace:                      \_\_\_\_\_                      Citizenship:                      \_\_\_\_\_

Additional Group Practice Name (if applicable):                      \_\_\_\_\_

\_\_\_\_\_

Additional Mailing Address:                      \_\_\_\_\_

\_\_\_\_\_

TAX ID Numbers:                      \_\_\_\_\_

Phone Number:                      \_\_\_\_\_                      Fax Number:                      \_\_\_\_\_

*Please send information to the following address:*                      Home                      \_\_\_\_\_                      Business                      \_\_\_\_\_

***Peer References***

Please list the names, and addresses of three professional references who are not relatives, who have directly observed or evaluated your work, and who would be willing to provide information to the Board in writing concerning your expertise in Pediatric Neuropsychology. You will also need to complete three releases, naming each of the individuals below so that we may contact them for these references.

REFERENCE 1

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

REFERENCE 2

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

REFERENCE 3

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

***Licensing or Certification***

State License or Certification Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please list additional State Licenses or Certification Numbers and Expiration Dates, if applicable:

1. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

***Education***

UNDERGRADUATE

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Degree: \_\_\_\_\_

Date Graduated: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PROFESSIONAL

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Degree: \_\_\_\_\_

Date Graduated: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

INTERNSHIP

Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Completed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

POST-DOCTORAL FELLOWSHIP

Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Completed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date Completed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



***Teaching and Clinical Work***

TEACHING

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Rank: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

School Name: \_\_\_\_\_

Address: \_\_\_\_\_

Rank: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

CLINICAL APPOINTMENTS

Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Appointments: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Appointments: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

*Please attach additional training information specifically related to Pediatric Neuropsychology and proof of attendance for the past 3 years. Include all applicable CEU courses attended.*

**Board Certification**

Specialty boards by which you are certified *that required examination of your competence in that skill area*:

➤ \_\_\_\_\_ Contact Person: \_\_\_\_\_

Certificate Number: \_\_\_\_\_

Date Certified: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

➤ \_\_\_\_\_ Contact Person: \_\_\_\_\_

Certificate Number: \_\_\_\_\_

Date Certified: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you believe that you are currently board eligible for either ABPP (CN) or ABPN?

YES                  NO                  (Circle one)

If you have ever been board certified, has this certification ever been suspended or revoked, or are such actions currently pending? (If “YES” please attach a detailed description and explanation)

YES                  NO                  (Circle one)

If applicable, date admitted to National Register: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Registration Number: \_\_\_\_\_

**Additional Professional Information**

Names of Professional Organizations, Academies, or Societies in which you hold membership:

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Please detail your TRAINING EXPERIENCE in Pediatric Neuropsychology, including dates, on a separate page

Please detail your WORKING EXPERIENCE in Pediatric Neuropsychology, including dates, on a separate page

***Professional Liability Insurance***

Current Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_

Retroactive Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Effective Dates: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ through \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Has your professional liability insurance coverage ever been terminated by action of an insurance company? (If “YES” please detail on a separate sheet)

YES NO (Circle one)

Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your professional specialty? (If “YES” please detail on a separate sheet)

YES NO (Circle one)

Please list all insurance carriers for the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Disciplinary Actions***

*If answers to any of the questions below are "YES," please detail on a separate sheet.*

Have any disciplinary actions ever been initiated and/or are pending now against you by any state licensing board?

YES                      NO                      (Circle one)

Has your license to practice medicine in any state ever been denied, limited, suspended, revoked or voluntarily relinquished?

YES                      NO                      (Circle one)

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, Medicaid, or any managed care company)?

YES                      NO                      (Circle one)

Have you ever been the subject of an investigation by any state, federal, or private agency concerning your participation in any state, federal, or private, health insurance program?

YES                      NO                      (Circle one)

Have any of your federal DEA number(s) or other controlled substance numbers ever been limited, suspended, revoked, or voluntarily relinquished, or are proceedings toward any of those ends currently pending?

YES                      NO                      (Circle one)

Has your application for appointment or reappointment, or your privileges at any hospital or other health care facility ever been denied, reduced, suspended or not renewed?

YES                      NO                      (Circle one)

Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization?

YES                      NO                      (Circle one)

***Legal Action***

*If answers to either of the following questions are “YES,” please attach detailed information. Explanations must include: county or jurisdiction in which the suit was filed; name of the plaintiff and the date the suit was filed.*

Have any professional liability claims, suits, or judgments ever been made against you or are such claims, suits, or judgments currently pending or have you ever been made aware that any will be filed?

YES                      NO                      (Circle one)

Have you ever been convicted of a felony or misdemeanor other than minor traffic violations?

YES                      NO                      (Circle one)

***Health Status***

Have you ever had, or are you currently aware of having any physical, mental or emotional condition, or chemical dependency/substance abuse problem which may interfere with your ability to care for patients in any way? (If the answer(s) to any part of this question is “YES,” please attach detailed information on a separate sheet)

YES                      NO                      (Circle one)

***Attestation***

I certify that all of the information provided herein is accurate. I understand and agree that if any of the information I have provided is proven to be false or misleading, if in the future my behavior results in the probation or suspension of my license, or I become the subject of an ethics investigation on the part of the APA or my State Psychological Association, my application may be rejected and/or my board certification status may be suspended or revoked. I agree to use my credentials appropriately and will not use the ABPdN credentials or any other credentials that I might have to mislead consumers or colleagues to believe that I have been trained or examined in areas other than that both truthful and accurate.

Applicant Name (Please Print): \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Name (Please Print): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please mail THREE (3) copies of this application to:**

**Peter Dodzik, PsyD, ABPdN, ABN  
415 West Golf Road, Suite 16  
Arlington Heights, IL 60005**

Application Fee Enclosed (\$350.00 USD)      YES      NO      (Circle one)

*NOTE: Additional fees are due and payable upon approval to move on to next phase of examination. The Board reserves the right to change its schedule of fees at any time during the course of candidacy.*

***Fees are not returnable***

*Schedule of Fees*

Application Package	No Charge
Application Fee	\$350.00 USD
Examination Fee (Written & Oral)	\$450.00 USD
Induction Fee	\$150.00 USD
Annual Dues	\$250.00 USD

***Patient Demographics***

Please list percentage for patient demographic groups (past 5 years):

Male: \_\_\_\_\_

Female: \_\_\_\_\_

0 – 5 \_\_\_\_\_

6 – 11 \_\_\_\_\_

12 – 16 \_\_\_\_\_

17 – 25 \_\_\_\_\_

26 – 55 \_\_\_\_\_

56+ \_\_\_\_\_

Please describe the cultural variability of your work:

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***Pediatric Neuropsychology Practice***

*On a separate page*, please describe your practice of Pediatric Neuropsychology for the last 5 years.

***Neuropsychological Testing Instruments***

*On a separate page*, please list those neuropsychological testing instruments with which you are very familiar and are comfortable with administering and interpreting. Please also include a rough estimate of the number of times you have administered each of these instruments.



***The American Board of Pediatric Neuropsychology***  
**Applicant's Consent and Release Form**

I hereby apply for participation with the American Board of Pediatric Neuropsychology (hereafter ABPdN) as requested in this application and am to make myself available for interviews in regard to said application.

As an applicant, I have the burden of producing adequate information for proper evaluation of my qualifications. I also agree to update the ABPdN with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the ABPdN or its authorized representatives. Failure to produce any such information will prevent my application from being evaluated and acted upon.

Information given in or attached to this application is accurate and complete to the best of my knowledge and ability. As a condition to making this application, any misrepresentation, misstatement, or omission, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of request for participation. In the event that certification has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of said certification. As a component of the credentialing and process, I accept the following conditions:

A) I extend absolute immunity to, and release from any and all liability, the ABPdN, its authorized representatives and any third parties (as defined in Subsection B below) for any acts performed in good faith, communications, reports, records, statements, documents, recommendations or disclosures involving me; performed, made, requested, or received by ABPdN and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to the following:

1. Applications for participation with ABPdN including temporary privileges;
2. Periodic reappraisals undertaken for re-credentialing;
3. Proceedings for suspension or reduction of clinical privileges or for denial or revocation of participation or my other disciplinary action
4. Medical care evaluations;
5. Utilization reviews
6. Any other ABPdN service or committee activities;
7. Matters of inquiries concerning my professional qualifications, credentials, clinical competence, character, ethics or behavior;
8. Matters of inquiries concerning my mental or emotional stability, or physical condition; and
9. Any other matter, which might directly impact or reflect on my competence, on patient care or on the orderly operation of a health care facility.

The foregoing may or may not be privileged as permitted by law. My release and immunity shall extend to ABPdN and its authorized representatives, and to any third party, regardless of whether my application is accepted; and if accepted, regardless of whether my membership and privileges as hereafter aforementioned are terminated, either voluntarily or involuntarily.

I specifically authorize ABPdN and its authorized representatives to consult with any third party who may have information including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, (mental or emotional stability, physical condition), ethics, behavior or any other matter bearing on my satisfaction of the criteria for initial or continued participation with ABPdN relating to such questions. I also specifically authorize said third parties to release said information to ABPdN and its authorized representatives upon request.

B) The term “authorized representatives” means the corporation(s) with which I have applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating my credentials, or acting upon my application: the members of ABPdN and Their appointed representatives, the Chief Executive Officer or his designees, other ABPdN employees, consultants to ABPdN, ABPdN attorney and his/her partners, associates or designees. The term “third parties” means all individuals, including appointees to ABPdN medical staffs of hospital or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested to ABPdN or its authorized representatives or who have requested such information from ABPdN and its authorized representatives.

Applicant Name (Please Print): \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Name (Please Print): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## *Case Vignettes*

The following case vignettes are purposely adaptable because we want you to be able to write about something that you know and do well. Please carefully read the instructions, circle the identifying variables you intend to use as your chosen demographic constraints, and keep your responses to no more than 3 typed, single-spaced pages. Please use either “Times New Roman” or a Courier font, no less than a pitch size of 12, margins of no less than 1” on all 4 sides. Finally, please paginate all pages and use a right-justified header with the following notation:

Your first and last initials followed by your birth date, the vignette #, followed by your application date (##/##/####). If done correctly, the header should look something like this:

JC01/01/1960 - 1 – 05/05/2003

Please note that you will not be given exhaustive historical materials in these vignettes, but often only case outlines. The examiners will be reviewing your thinking and questioning process about these cases, so do not get caught up in being overly concerned about the data you don’t have. Rather, respond to the material as best you can (just like all other candidates will do as well – sometimes this is helpful to remember).

Finally, there are three vignettes provided. *You must respond to one of the vignettes for your application to be considered “complete.”*

Finally, we want evidence of *your* critical thinking. We do not want a list of citations or quotes other sources. Treat this as you would a patient referral to your practice.

*For the purpose of your response, please choose the age at which you are presuming to have had this child introduced to your practice. For instance, if you wish to write about this child at 3, simply circle and define this as the age. If you wish to answer this question presuming that you first saw this child at age 16, then circle and define your responses as such.*

### *Vignette I*

The patient (S.C.) is a 3 8 12 16 year old male with a history of head injury at 1 year of age. Prior to the head injury, his history included a normal maternal pregnancy, uneventful delivery, developmentally unremarkable maturation through the predicted milestones, and the presence of loving and attentive parents. The injury occurred as a result of a fall from a crib. The fall was heard by the parents who rushed to find the child on the floor, unconscious, and unresponsive. The length of unconsciousness was estimated to be near 10 minutes. When the paramedics arrived, they found the child to be obtunded, though clearly more responsive. The child was taken to the hospital, found to have no CT abnormalities, and to be dramatically improved within 24 hours. He was released the following day.

At 3 years of age, this young child began to demonstrate seizures that were ultimately described as petit mal. He was placed on medication and was seen by a pediatric neurologist for this care.

This child demonstrates considerable behavioral problems. The parents are concerned that the child is not learning or developing as efficiently as they predicted, that he seems disinterested in tasks or behaviors consistent with others in his age group, and they have heard from other parents and/or professionals that he appears to be falling behind others in peer group.

Please define your likely initial intervention with this child (and, perhaps, his family). In your response, please discuss your rationale, the possible complicating outcomes, and your potential responses to these. Comment about data that you feel you need but don't have and why that data was important. Discuss referrals you might make and why. If you decide to use any neuropsychological testing instruments, please define the measures and provide your rationale for the selection of those instruments.

## *Vignette II*

You are referred a child for neuropsychological evaluation by a local pediatric neurologist. The child was referred to the neurologist because the child was demonstrating symptoms of hyperactivity, poor attention to age appropriate tasks, and reading skills that are not consistent with his peer group. This child is (choose 6 8 10 12 14 16) years of age. The neurologist has indicated that the neurological examination is essentially normal, including MRI and EEG. Blood work is also normal.

This neurologist has referred the child to you requesting that you help the parents define the correct behavioral diagnosis, establish the child's cognitive strengths and weaknesses, assist the school in defining the reading difficulties, and make recommendations for his consideration regarding possible pharmacological support.

Please design a reasonable examination protocol that will enable you to assist the neurologist, the family and the school. Discuss your rationale for the tests you select and for any other procedures that you believe will likely be necessary to arrive at the recommendations that you ultimately provide to the parties above.

*Finally, do not forget to choose the age at which you are presuming to have had this child introduced to your practice. For instance, if you wish to write about this child at 6, simply circle and define this as the age. If you wish to answer this question presuming that you first saw this child at age 16, then circle and define your responses as such.*

### *Vignette III*

You are referred a (5, 8, or 11) year-old Caucasian child. The child is a public school, Kindergarten student. The child was referred because of the following behaviors:

Poor attention and concentration when doing seatwork despite good attention during story time; Isolation during recess and inability to establish peer relationships; Poor gross and fine motor skills including difficulty printing, cutting, and drawing; Unusual behaviors including flapping, hypersensitivity to noise in the cafeteria, perseveration on the theme of dinosaurs as well as needing to be first in line. Although the child appears to be verbally bright, he/she sometimes doesn't make sense and obtained an intellectual score in the Borderline range when tested by another psychologist.

Questions:

1. Detail what information will you want to obtain from the family and why?
2. What further information will you want to obtain from the teacher?
3. What might be your hypothesis as to the reason for this child's problems?
4. Why might this child, who appears to be verbally bright, score in the Borderline range on an IQ test?
5. What tests would you include in your battery and why?
6. What are some recommendations you might make to the school before you begin your evaluation and why?

*Finally, do not forget to choose the age at which you are presuming to have had this child introduced to your practice. For instance, if you wish to write about this child at 5, simply circle and define this as the age. If you wish to answer this question presuming that you first saw this child at age 11, then circle and define your responses as such.*



***American Board of Pediatric Neuropsychology***  
**Letter of reference**

**Applicant Name:** \_\_\_\_\_

**Applicant Address:** \_\_\_\_\_

**Applicant Phone:** \_\_\_\_\_

**Reference Name:** \_\_\_\_\_

**Reference Address:** \_\_\_\_\_

**Reference Phone:** \_\_\_\_\_

I hereby release the party above to provide a reference for me pursuant to my application for board certification with the American Board of Pediatric Neuropsychology. I further waive my right to review the letter of reference or any information contained on this document in the interest of obtaining said reference.

\_\_\_\_\_  
Applicant Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

\*\*\*\*\*

I have known the above applicant for \_\_\_\_\_ years.

My knowledge of the applicant's skills in pediatric neuropsychology is based upon \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I consider this person to demonstrate competence in his/her practice of pediatric neuropsychology.

**True**      **False**      **Unknown**      (Please circle one)

I **have** / **have no** (circle one) reservations in recommending this individual for board certification in pediatric neuropsychology. (If you have reservations, please elaborate on a separate page.)

\_\_\_\_\_  
Reference Signature

\_\_\_\_\_  
Date

*Please attach additional explanatory pages if desired.*