Declaration of Training and Employment

This section must be completed in detail.
Please indicate the name and email address of the Physician Electromyographer(s) and registered EMG technologist(s) who have supervised your training and employment. Specify the number of patients you have tested with assistance and without assistance.

Facility and address	Start date	End date	Physician name and email	R.T.(EMG) name and email	# of patients tested	
					Assisted	Unassisted

I, _____(candidate name, please print) declare the above information to be a true representation of my training and work experience in NCS.

_____ _____

Signature Date

Declaration of Supervision

THE BOARD OF ELECTROMYOGRAPHY TECHNOLOGISTS OF CANADA
B.R.E.T.C.

This section to be completed by a supervising physician electromyographer practicing in North America

I have read the previous statements and information provided by the applicant, including the fact that this individual has (or will have by May 30, 2026) completed a variety of unassisted nerve conduction studies on at least 1,000 patients after the completion of training, and witness these statements to be true and accurate.

Name: _____

Email: _____

Phone: _____

Date: _____