



**National Consortium of Breast Centers, Inc.  
Clinical Breast Examiner Certification  
Annual Renewal of Certification Form**

**Respondent:**

**Name** \_\_\_\_\_  
**Professional Credentials** \_\_\_\_\_  
**Facility Name** \_\_\_\_\_  
**Facility Address** \_\_\_\_\_  
 \_\_\_\_\_  
**City, State ZIP** \_\_\_\_\_  
**Daytime Phone Number(s)** \_\_\_\_\_  
 \_\_\_\_\_  
**Initial Year of CBE Certification** \_\_\_\_\_  
**Renewal of CBE Certification Requested for Year** \_\_\_\_\_  
**Data Being Submitted Represents Patients Seen in Year** \_\_\_\_\_

**Instructions:**

To renew CBE Certification, complete this form and submit according to the schedule determined by the initial year of certification. Provide cumulative data on ten (10) consecutive CBE or CPBA patients during the 12-month period of time as determined by your initial certification year. For ease of collection and calculation, patient's data should be collected/identified as soon as possible following imaging/pathology reports.

Please have your supervisor, medical director or a physician on staff sign off on your responses to validate your information.

The required data must be submitted to and received by the NCBC office no later than December 31<sup>st</sup> of the year preceding the year for which renewal of certification is being requested. There is no fee for renewal of certification.

**Data:**

- I.                   A. \_\_\_\_\_ Estimated number of CBEs / CPBAs performed annually
- II.   The following data shall cover at least 10 consecutive patients during the 12-month period dependant upon initial certification year. This data was collected for patients seen in year \_\_\_\_\_
  - A. \_\_\_\_\_ number of asymptomatic patients with positive clinical findings found on CBE / CPBA
  - B. \_\_\_\_\_ number of symptomatic patients with negative clinical findings found on CBE / CPBA
  - C. \_\_\_\_\_ number of symptomatic patients with positive clinical findings found on CBE / CPBA congruent with chief complaint
- III.   Anecdotal (incidental) information:  
Situations of interest you would be willing to share to assist other Certified CBE / CPBA in their practices.

**Validation:**

<b>Printed name</b>	<b>Signature</b>
<b>Title</b>	<b>Date</b>

**Submit to:**

National Consortium of Breast Centers, Inc.

Mail: P.O. Box 1334

Warsaw, IN 46581-01334

Fax: 574-267-8268

Email: NCBC@breastcare.org