IBBM PBMT Initial Certification Application: Case Report Form

Please enter in at least fifty (50) clinical cases utilizing cell saver technique performed during the previous year. This list must include the Hospital/Clinic, date, surgeon, procedure performed, Surgeon, Procedure Type, Adult/Pediatric. Procedures must be specific (Total Hip Arthroplasty, Posterior Spinal Fusion, etc.). Procedure categories will not be accepted (Ortho, Vascular, Emergency, Heart, etc.). Procedure Type must be Autotransfusion, Platelet Gel or Stem Cell

Please submit your completed form to ibbm@amsect.org

Case #	**Date** (Ex: 01/12/2018)	**Facility Name**	**Proedure**	**Surgeon Last Name**	**Procedure Type: Ex: Autotransfusion, platelet gel, stem cell**	**Adult or Pediatric**
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