This list of reading and/or reference materials is helpful in understanding the practical and theoretical aspects of clinical electrophysiology. The compilation of this list in no way implies that AAEE examination question are derived from these materials nor is it felt necessary to read all of the material listed when preparing to take the examination.

We recommend that all residents read Dr. Jun Kimura's *Electrodiagnosis in Diseases of Nerve and Muscle: Principles and Practice* during the first month in the EMG laboratory. Kimura contains an excellent discussion of anatomy, nerve conduction study and electromyography technique and instrumentation, and pathophysiology of neuromuscular disease. In subsequent months, draw from the other references listed here in addition to Kimura.


37. Van Holsbeeck MT, Introcaso JH. Musculoskeletal ultrasound. 2nd ed. St. Louis, Mo: Mosby; 2001

**Journals – EMG articles including current literature in the following journals:**

- American Journal of Physical Medicine
- Annals of Neurology
- Archives of Neurology
- Archives of Physical Medicine and Rehabilitation
- Brain
- Electroencephalography and Clinical Neurophysiology
- Electromyography and Clinical Neurophysiology
- Journal of Clinical Neurophysiology
- Journal of the Neurological Sciences
- Journal of Neurology, Neurosurgery and Psychiatry
- Muscle & Nerve
- Neurology

In addition, there are many useful materials which can be obtained through the AANEM office. These include videotapes and publications such as case reports, course and meeting handouts, guidelines and a glossary.
RECOMMENDED EDUCATIONAL REQUIREMENTS
FOR THE PRACTICE OF ELECTROMYOGRAPHY AND ELECTRODIAGNOSTIC MEDICINE

1. It is recommended that electromyographers have completed an approved neurology or physical medicine and rehabilitation residency, or equivalent medical specialty graduate training program, that included adequate educational experience in:
   a. Anatomy.
   b. Pathology of muscle and nerve.
   c. Neuromuscular physiology.
   d. Electrophysiology - including instrumentation, quantification and statistical analysis.
   e. Clinical aspects of neuromuscular and skeletomuscular diseases as they pertain to clinical electromyography.

2. In addition, a period of preceptorship in electromyography that is coordinated with presentation of didactic material should be completed under direct supervision of an experienced electromyographer, preferably an active member of the American Association of Electromyography and Electrodiagnosis. This preceptorship may be taken during or after an approved residency training program.

   The period of preceptorship should be at least six months full time, or equivalent thereof, and the first three months should be rigidly structured with regard to supervision. It is recommended that any part-time post-training course of study in electromyography be in a laboratory at a center where there is a recognized residency training program to qualify as a portion of the six-month preceptorship. During these six months at least 200 patients should be examined; these studies should be documented and interpreted, and should include representative neuromuscular disorders in adults and children.

3. Competency in clinical electromyography can only be achieved with at least one more year performing and interpreting electromyographic examinations on an additional 200 or more patients. This period of independent experience can only begin after completion of an approved residency training program and completion of the six-month preceptorship. The year of independent experience may be part of a post-residency program when, in the judgment of the membership committee, the candidate has been given primary responsibility for the performance, interpretation and preparation of the electromyography report. Membership Committee review will include solicitation of supporting letters from laboratory directors.

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The American Association of Electromyography and Electrodiagnosis will only accept candidates for examination who have satisfactorily completed recommended educational requirements as outlined. These must be met by the application deadline of February 1.
American Association of Electromyography and Electrodiagnosis
732 Marquette Bank Building
Rochester, Minnesota 55904

EXAMINATION FOR ACTIVE MEMBERSHIP

AAEE Examination Objectives

The purpose of the American Association of Electromyography and Electrodiagnosis, as defined in the Goals Statement, is to maximize understanding of neuromuscular disorders through appropriate use of clinical electromyography and related neurophysiologic techniques by promoting programs of education, research and quality assurance. The objective of the AAEE annual examination is to aid in the third purpose of quality assurance by testing competence of candidates for membership and admitting to active membership those who have passed the examination. The examination, therefore, defines and evaluates what the AAEE believes are minimal standards of competence for physicians practicing clinical electrodiagnostic medicine.

A clinical EMG is a medical consultation in the specialized area of neuromuscular diseases using electrophysiologic techniques. The electromyographer must be able to elicit the pertinent history and perform the necessary physical examination to define the clinical problem and must then select and perform a logical sequence of electrophysiologic tests to efficiently obtain the necessary data for elucidation of the problem. He/she must, finally, interpret the data to establish the diagnosis, prognosis and treatment of the patient. The electromyographer, therefore, needs to be a physician who has had special training in the diagnosis and treatment of neuromuscular diseases and is also an expert in the utilization of the tools of electrodiagnostic medicine for studying these disorders. The training should include all the basic sciences pertinent to the understanding of these diseases, and additional special knowledge necessary for the electrophysiologic determination.

Qualifications can be subdivided into three areas: 1) knowledge of disciplines related to the diagnosis of neuromuscular diseases, 2) skill at performing an electrodiagnostic examination, and 3) ability to recognize EMG patterns displayed on an oscilloscope screen and loudspeaker. The examination is subdivided into three parts, each designed to evaluate one of these areas of competence. Every candidate must pass each part.

To pass the examination, a candidate must have an average score of 70% or better for the three parts of the examination, and must have a score of 60% or better on each part of the examination. If a candidate fails all or any part of the examination, the entire examination must be taken again to become an active member.
Part I of the examination is a three-hour, multiple-choice examination which tests knowledge in the areas of:

1. Anatomy.
2. Physiology and pathophysiology.
3. Nerve conduction techniques, including somatosensory evoked potentials.
4. Electromyography.
5. Clinical disorders and problem solving in electrodiagnostic medicine.
6. Instrumentation.

Part II of the examination is a one-hour, multiple-choice examination which tests the ability to identify electrical potentials recorded with standard concentric needle electrodes, and displayed on TV monitors, in a simulation of an EMG examination. All items are displayed with standard settings: sweep speed - 5-100 ms/cm (50-1000 ms total sweep); gain - 50, 100, 250 or 500 μV/cm; and polarity - negative up.

Candidates are asked to describe and identify the EMG potentials and then firing patterns and interpret their significance. Candidates must recognize typical examples of:

1. Motor unit potentials: normal, small, large, varying, polyphasic, tremor, poor recruitment, doublets.
2. Spontaneous activity: fibrillations, positive sharp waves, fasciculations, myotonic discharge, biphasic end-plate activity, monophasic end-plate activity, myokymia, complex repetitive discharges, cramp discharge, neuromyotonia.

Part III is a 45-minute oral examination which tests practical and technical skills in carrying out an examination in electrodiagnostic medicine. There will be two examiners, one a neurologist and the other a physiatrist, who will test ability to:

1. Apply stimulating and recording electrodes.
2. Identify locations and functions of major muscles and nerves.
3. Use special techniques such as repetitive stimulation, reflex measurements, single fiber EMG, somatosensory evoked potentials.
4. Recognize and interpret abnormalities on nerve conduction studies.
5. Recognize and interpret abnormalities on the needle exam.
6. Most importantly, logically approach and solve a clinical problem.

The examination is given on two days, with Parts I and II being on the first day and Part III being on the second. Examples of examination questions are attached. Currently no part of the examination relates to auditory and visual evoked potentials.
AAEE Examination Examples

Examples of Part I

1. Increasing the stimulus intensity from supramaximal to twice the supramaximal level when stimulating a peripheral nerve will:
   a. Decrease the latency of the response.
   b. Increase the response amplitude due to cathodal potentiation.
   c. Have no effect to the latency or amplitude.
   d. Decrease the response amplitude due to anodal blocking.
   e. Increase the speed of volume conduction.

2. In a depolarized segment of axon during the passage of an action potential:
   a. The sodium conductance is decreased.
   b. The potassium conductance is increased.
   c. The membrane potential is at - 50 mV.
   d. Sodium ions are flowing out.
   e. The membrane is not refractory to stimulation.

3. A newborn baby (four pounds in weight) had the following conduction studies:
   peroneal, 30 m/s; median, 28 m/s. Which of the following is the most correct interpretation:
   a. The baby is a full-term baby with a low weight.
   b. The baby is premature.
   c. The baby has a demyelinating neuropathy.
   d. Measurement errors make values in infants useless.
   e. There is evidence of a neural lesion in the arm.

Examples of Part II (These questions cannot be answered without viewing the videotape, but they are representative.)

Wave Form One: 250 microvolt calibration signal.
   vastus lateralis muscle.
   thirty-year-old man.

1. The wave form of these potentials is:
   a. Monophasic.
   b. Diphasic, initial phase negative.
   c. Diphasic, initial phase positive.
   d. Polyphasic.
   e. None of the above.

2. The firing pattern of these potentials is:
   a. Regular and less than 20 per second.
   b. Irregular and less than 20 per second.
   c. Regular and more than 20 per second.
   d. Irregular and more than 20 per second.
   e. Too variable to determine.

3. These potentials are called:
   a. Fasciculations.
   b. Myotonic discharges
   c. Positive waves.
   d. Motor unit potentials.
   e. Normal insertional activity.

4. These potentials would be most prominent in:
   a. Duchenne dystrophy.
   b. Marfan's syndrome.
   c. Chloroquine myopathy.
   d. Normal muscle.
   e. Amyotrophic lateral sclerosis.
Sample of Question Involving Photographic Interpretation

Recording electrode extensor digitorum brevis:
A. Peroneal nerve stimulated above the knee.
B. Peroneal nerve stimulated below the fibula.
C. Peroneal nerve stimulated at the ankle.
Stimulation is at the time of the arrow.

1. Diagnosis:
   a. Generalized peripheral neuropathy.
   b. Accessory peroneal nerve.
   c. Crossed leg palsy.
   d. Artifact.
   e. Normal.

2. Which best describes the condition of the nerve?
   a. Neurapraxia.
   b. Axonal neuropathy.
   c. Neuronotmesis.
   d. Generalized demyelination.
   e. Normal.
AAEE 1982 CONTINUING EDUCATION COURSE (A)
Self-Assessment Test

Select the ONE best answer for each question.

1. Assume the length of the spread of depolarization during conduction in a sensory nerve is 40 mm. To achieve a maximum peak-to-peak amplitude, how far apart should the surface electrodes be for recording the evoked action potential?
   a. The electrodes should be less than 4 cm apart.
   b. The electrodes should be at least 4 cm apart.
   c. The distance between the electrodes is not important since the duration of the volume-conducted action potential is just a few ms.
   d. The interelectrode distance should be one half the depolarization length or 2 cm apart.
   e. a and d above.

2. An electromyographer completes a sensory conduction study and decides to also perform a needle electromyographic examination. He fails, however, to restore the high-frequency response of his amplifier to his usual 8 to 10 kHz. Which of the following will turn out to be true?
   1. The amplitudes of the motor unit action potentials will come out smaller.
   2. The action potential durations will come out longer.
   3. The number of phases of a polyphasic action potential may end up reduced.
   4. Actually, he should have had the amplifier set at 8 or 10 kHz when he did the sensory evoked potential.
   a. 1, 2 and 3
   b. 1 and 3.
   c. 2 and 4.
   d. 4 only.
   e. All of the above.

3. A median nerve motor evoked potential is being performed by an electromyographer who remembered that he must be supramaximal with his stimulation. He keeps increasing the size of the stimulus delivered to the patient and shocks the patient with each increment. He reaches a point where he notices that the amplitude and shape of the evoked response do not change with each increment, but that the latency keeps getting shorter. His conclusion is which of the following?
   a. That's all right, because the fastest fibers have the larger diameters and they require more current for depolarization to be induced.
   b. It probably means that the ulnar nerve has also been stimulated.
   c. It means that the motor nerve action potential is being initiated distal to the location of the cathode.
   d. a and c above can both be correct.
   e. a and b above can both be correct.

4. Which of the following is true with regard to needle electrode impedance and amplifier input impedance?
   1. Amplifier impedance is the same for all frequencies.
   2. Needle impedance is higher at the lower frequencies than at the higher frequencies.
   3. Both needle and amplifier impedance decrease with frequency.
   4. Needle impedance should be 100 to 1,000 times higher than amplifier input impedance.
   a. 1, 2 and 3.
   b. 1 and 3.
   c. 2 and 4.
   d. 4 only.
   e. All of the above.

5. Calculate the maximum amount of experimental error in a conduction velocity determination, given the following data.
   1. Distance between the two points of stimulation = 20 cm.
   2. Time of conduction of the impulse from one point of stimulation to the other = 4 ms.
   3. Known experimental error in the distance measurements = 6 mm.
   4. Known experimental error in the conduction time = 0.4 ms.
   a. 2.5 meters per second.
   b. 3.0 meters per second.
   c. 4.0 meters per second.
   d. 6.5 meters per second.
   e. 4.5 meters per second.

6. Inadvertent reversal of G1 and G2 in otherwise conventional belly-tendon recordings of an M response results in which of the following?
   a. Initially upward deflection.
   b. Initially downward deflection.
   c. Increase in latency.
   d. Decrease in amplitude.
   e. None of the above.

7. The presence of normal sensory action potentials in clinically anesthetic hands indicates that the lesion is located in which of the following?
   a. Central somatosensory pathway.
   b. Peripheral somatosensory pathway.
   c. Distal to the sensory ganglion.
   d. Proximal to the sensory ganglion.
   e. None of the above.
8. Studying median nerve sensory potential by surface electrodes, digital nerve potential recorded antidromically is usually higher in amplitude than orthodromic nerve action potential recorded at the wrist. Which of the following statements is true?
   a. Antidromic recording gives better synchronization.
   b. Areas under the antidromic and orthodromic potentials are the same.
   c. Orthodromic stimulation tend to be submaximal.
   d. Orthodromic impulse is partially blocked under the carpal ligament.
   e. None of the above.

9. Differentiation between neurapraxia and neurotomies can be accomplished if:
   a. The nerve is stimulated proximal to the site of lesion.
   b. A collision technique is used.
   c. A needle electrode is inserted near the lesion.
   d. A conduction study is done within four days after the presumed injury.
   e. None of the above.

10. A nerve conduction velocity was 40 m/s at 31°C. What would it have been at 34°C?
    a. 34 m/s.
    b. 38 m/s.
    c. 42 m/s.
    d. 46 m/s.
    e. 50 m/s.

11. Fibrillation potentials are most reliably distinguished from end-plate spikes by which of the following?
    a. Presence of a negative spike.
    b. Duration of negative spike.
    c. Regularity of discharge.
    d. Polarity.
    e. Location.

12. Which of the following can be seen as positive waves?
    a. Fibrillation potentials.
    b. Motor unit potentials.
    c. Myotonic discharges.
    d. End-plate spikes.
    e. All of the above.

13. Which of the following is true in regard to a motor unit potential?
    a. It has a distinct firing pattern.
    b. It usually is initially positive.
    c. It has one amplitude and duration for each motor unit.
    d. It has rise time of diagnostic significance.
    e. It is derived from one or two muscle fibers.

14. Which of the following has the least effect on the size of a normal motor unit potential?
    a. Temperature
    b. Patient's age
    c. Muscle selected
    d. Electrode type
    e. Rate of discharge

15. Which of the following has the most constant rate of discharge?
    a. Complex repetitive discharge
    b. Myotonic discharge
    c. Fasciculation potential
    d. Myokymic discharge
    e. Motor unit potential

16. Which of the following has the highest rate of discharge?
    a. Myokymic discharge
    b. Fibrillation potential
    c. Myotonic discharge
    d. Neuromyotonic discharge
    e. Muscle cramp

17. Which of the following would be least likely with myokymic discharges?
    a. Guillain-Barre syndrome
    b. Radiation neuropathy
    c. Medulloblastoma
    d. Multiple sclerosis
    e. Tetany

18. Which of the following occur with myasthenia gravis?
    a. Fibrillation potentials
    b. Short-duration motor unit potentials
    c. Varying motor unit potentials
    d. All of the above
    e. None of the above

19. Which of the following would be the most common EMG error in Parkinson's disease?
    a. Large motor unit potentials
    b. Excess polyphasic motor unit potentials
    c. Small motor unit potentials
    d. Fasciculation potentials
    e. Fibrillation potentials

20. The results of motor nerve repetitive stimulation studies for detection of a defect of neuromuscular transmission can be affected by which of the following?
    a. Muscle temperature
    b. Anticholinesterase medication
    c. Previous muscle activity
    d. a and b above
    e. a, b, and c above
Select the ONE best answer for each question.

21. A decrementing response with repetitive motor nerve stimulation (2/s) can be seen in which of the following?
   a. Myasthenia gravis.
   b. Amyotrophic lateral sclerosis.
   c. Polymyositis.
   d. a and b above.
   e. a, b, and c above.

22. An incrementing response with repetitive motor nerve stimulation (10-25/s) is frequently seen in which of the following?
   a. Myasthenia gravis.
   b. Myasthenic syndrome.
   c. Neurasthenia.
   d. a and b above.
   e. a, b, and c above.

23. Which is the most sensitive electrophysiologic study to detect a defect of neuromuscular transmission?
   a. Concentric needle electromyography.
   b. Single fiber electromyography (SFEMG) (fiber density measurement).
   c. SFEMG (jitter measurements).
   d. Repetitive motor nerve stimulation (stimulus rate 2 to 3/sec).
   e. Repetitive motor nerve stimulation (stimulus rate 10 to 25/sec).

24. Identify the incorrect association between the condition and the site of neuromuscular junction damage:
   b. Botulism: postsynaptic.
   d. Curare: postsynaptic.
   e. Magnesium intoxication: presynaptic.

25. When recording from single muscle fibers, latency variability of consecutive F waves is which of the following?
   a. Greater than that of H reflex.
   b. About the same as that of H reflex.
   c. Less than that of H reflex.
   d. Less than that of M response.
   e. Difficult to determine for accurate comparison.

26. In trying to obtain an H reflex, one should select stimulus intensity to record which of the following?
   a. Minimal F wave.
   b. Minimal M response.
   c. Maximal H reflex.
   d. Minimal H reflex.
   e. None of the above.

27. Axon reflexes are usually but not always seen in which of the following?
   a. With repetitive stimulation.
   b. Between M response and F wave.
   c. With supramaximal stimulation.
   d. In chronic myopathies.
   e. In spastic conditions.

28. In a patient with facial palsy on the right, R1 of the blink reflex is delayed on the affected side. R2 is likely to be which of the following?
   a. Absent or delayed bilaterally with stimulation on the right.
   b. Absent or delayed bilaterally with stimulation on the left.
   c. Absent or delayed on the right regardless of the side of stimulation.
   d. Delayed bilaterally on glabellar tap.
   e. None of the above.

29. The accessory deep peroneal nerve usually innervates which of the following?
   a. Medial portion of the extensor digitorum brevis.
   b. Medial portion of the extensor hallucis.
   c. Lateral portion of abductor hallucis.
   d. Medial portion of abductor hallucis.
   e. None of the above.

30. You are asked to evaluate a 56-year-old woman with arm pain for a possible carpal tunnel syndrome. You perform a median sensory response and record an amplitude of 5 μV and a latency of 4.2 ms (14-cm distance). What is your conclusion at this point?
   a. Normal study; no evidence of a carpal tunnel syndrome.
   b. Probable radiculopathy; proceed to needle examination.
   c. Abnormal study; diagnostic of median neuropathy at the wrist.
   d. Insufficient data base for diagnostic conclusion.
   e. Abnormal study; diagnosis of median neuropathy but nonlocalizable.

31. A 68-year-old man with progressive weakness and atrophy of both arms and a spastic paraparesis of lower limbs has fibrillation potentials and positive waves with large-amplitude, polyphasic motor units in distal upper extremity muscles bilaterally. Clinical sensory examination is normal. A decremental ulnar motor response is demonstrated with ulnar motor nerve stimulation at low rates (2 Hz). Which of the following statements is true in regard to the finding?
   a. It is probably due to technical error.
   b. It may reflect abnormal neuromuscular transmission secondary to recent reinnervation.
Select the ONE best answer for each question.

c. Confirms the diagnosis of amyotrophic lateral sclerosis.
d. It enlightens you to the secondary diagnosis of superimposed myasthenia gravis.
e. None of the above.

32. A 50-year-old man with diffuse weakness has normal sensory conduction studies (sural, median), but all motor responses are of markedly reduced amplitude. At this point you should strongly consider which of the following?
a. A screening needle examination looking for myotonia.
b. Exercising the patient for one minute and performing repetitive stimulation (2 Hz) three minutes after exercise.
c. Checking the amplifier gain; it may still be set for the sensory studies.
d. Looking for facilitation of the motor response immediately after five seconds of maximal voluntary contraction.
e. Concluding the diagnosis is either a polyradiculopathy or diffuse motor polyneuropathy.

c. Sensory responses disappear or become substantially diminished within five to seven days after axonal degeneration in the nerve root.
d. Fibrillation potentials do not appear in any muscle innervated by the nerve root for 21 to 24 days.
e. Distal motor latencies become markedly prolonged prior to disappearance of the evoked response.

36. A 44-year-old woman developed over eight weeks an asymmetric flaccid paresis of both legs and perineal sensory loss. Your evaluation demonstrates normal sensory responses (including sural), absent lower extremity motor responses, and 4+ fibrillation potentials with a marked decrease in recruitment in lower extremity muscles, lumbosacral paraspinal muscles, and the rectal sphincter. Which of the following statements is true concerning these findings?
a. They suggest severe upper neuron involvement and raise the question of multiple sclerosis.
b. They may be explained by severe, bilateral lumbosacralplexopathies.
c. They are consistent with an inflammatory myopathy involving primarily the lower limbs.
d. They are consistent with a polyradiculopathy as seen, eg, in meningeal carcinomatosis.
e. None of the above.

33. Possible etiologic factors for low-amplitude or absent evoked responses in either sensory or motor studies include which of the following?
a. Stimulator not over the nerve.
b. Recording electrode inappropriately placed.
c. Stimulator anode and cathode reversed.
d. Electrodes not plugged in machine.
e. All of the above.

34. Which of the following statements is true in regard to evaluation of a patient with arm pain?
a. It can be limited to needle electromyography only if an adequate selection of muscles is included.
b. It is consistent with a C8 radiculopathy if ulnar sensory responses are absent with normal median sensory studies.
c. It should proceed until an abnormal value is found on either conduction studies or needle electromyography.
d. It requires needle examination of all four extremities if no abnormality is found in the symptomatic limb.
e. None of the above.

35. Following injury to a nerve root resulting in extensive axonal degeneration:
a. Abnormal recruitment is the first detectable electrodiagnostic abnormality.
b. Complex motor unit potentials appear within 24 hours of injury.
c. Sensory responses disappear or become substantially diminished within five to seven days after axonal degeneration in the nerve root.
d. Fibrillation potentials do not appear in any muscle innervated by the nerve root for 21 to 24 days.
e. Distal motor latencies become markedly prolonged prior to disappearance of the evoked response.

37. You are asked to evaluate a patient with a suspected peripheral neuropathy. You find absent sural, peroneal, and tibial responses in association with chronic neurogenic changes on needle electromyography of distal extremity muscles. Which of the following should be your next procedure?
a. Report your findings as consistent with a peripheral neuropathy.
b. Suggest clinical correlation.
c. Perform additional studies of less severely involved nerves.
d. Recommend an evaluation for diabetes mellitus.
e. Suggest SFEMG to determine muscle fiber density.

38. The presence of both large- and small-amplitude fibrillation potentials and positive waves in combination with highly polyphasic, long-duration, high-amplitude motor unit potentials with reduced recruitment suggests which of the following?
a. A chronic neurogenic disorder with ongoing degeneration.
b. Conclusive evidence of amyotrophic lateral sclerosis.
c. The possibility of improper electrode impedance.
d. Abnormal neuromuscular transmission as seen following denervation.
e. None of the above.
39. Temporal dispersion of the compound muscle action potential following proximal as compared to distal nerve stimulation may result from which of the following?
   a. Decreased conduction velocity in some fibers compared to others, increasing the range of conduction velocities.
   b. Improper filter settings, tending to accentuate low-frequency responses.
   c. Severe axonal degeneration involving greater than 80% of the nerve axons.
   d. Focal demyelination located proximal to both stimulation sites.
   e. None of the above.

40. In suspected motor neuron disease, which of the following statements is true in regard to the needle examination?
   a. It is unnecessary if gross fasciculations are present in at least three extremities.
   b. Demonstrating denervation in two extremities makes a definite diagnosis of ALS.
   c. It should begin with evaluation of clinically normal muscles because fibrillation potentials are most likely overlooked here.
   d. It should be performed so as to localize the abnormality to a single nerve or root before looking for widespread changes.
   e. It should not result in an extensive evaluation of clinically normal muscles if clinically involved muscles show no abnormality.

41. Which of the following statements is true in regard to patients with inflammatory myopathy?
   a. Abnormalities in the compound muscle action potential amplitude are prominent and widespread.
   b. Sensory studies are not necessary.
   c. Abnormalities on needle examination are most prominent in proximal muscles.
   d. A decremental ulnar motor response to repetitive stimulation is an expected finding.
   e. None of the above.

42. Overall, did the course meet your expectations?
   a. Yes.
   b. No.

43. As a result of the course, did you learn anything new?
   a. Yes.
   b. No.

44. As a result of the course, will you do anything differently in your approach to your patients?
   a. Yes.
   b. No.

45. As a result of the course, will you try new techniques in your office or laboratory?
   a. Yes.
   b. No.

46. Do you approve of a dual course (basic and advanced) such as was offered this year?
   a. Yes.
   b. No.

47. Were the topics chosen appropriate?
   a. Yes.
   b. No.

48. Was the time allotted for each presentation adequate?
   a. Yes.
   b. No.

49. Was the time allotted for discussion adequate?
   a. Yes.
   b. No.

50. Were the general facilities adequate?
   a. Yes.
   b. Too crowded.
   c. Unsatisfactory in other ways.

51. Were the projection facilities adequate?
   a. Yes.
   b. No.

52. Were the audio facilities adequate?
   a. Yes.
   b. No.

53. Is this handout:
   a. Satisfactory.
   b. Too lengthy.
   c. Too short.
   d. Poorly edited.

54. Was the test:
   a. Satisfactory.
   b. Too lengthy.
   c. Too short.
   d. Poorly written.
   e. Unnecessary.