Application for Certification

(Please type or print)

I. Personal Data:

A. Name ______________________________________ Daytime Phone or email address: ____________________

B. Address ____

C. References (Name - Address - Telephone)

1. . ____________________________ ____ (   ) _____________

2. . ____________________________ ____ (   ) _____________

3. . ____________________________ ____ (   ) _____________

II. Employment History in the field of Disability Evaluation and/or Assessment.

Applicant must have a minimum of three years experience.
Please list full names and addresses and beginning and ending dates starting with current employment and working back.
Need only account for necessary three years.

1. Name of Employer ____________________________________ Date started: ________ Date ended: ________

Address ____

2. Name of Employer ____________________________________ Date started: ________ Date ended: ________

Address ____

3. Name of Employer ____________________________________ Date started: ________ Date ended: ________

Address ____

Ill. Present Job Title: ____

IV A. Educational Training:
(Please restrict to college or university training. List complete school name and address.)

1. School: ________________ Major: ____________ Minor: ____________ Degree: _______ Year: __________

2. School: ________________ Major: ____________ Minor: ____________ Degree: _______ Year: __________

3. School: ________________ Major: ____________ Minor: ____________ Degree: _______ Year: __________

B.

1. Does your agency require a degree? (For examiners only) ____________________________________

2. Are you currently licensed in your specialty? __________ (For Medical Consultants only - Skip to Part V)

C. Specialized Training - Disability Examiners - Must have completed a minimum of 36 hours medical, 24 hours vocational and 12 hours technical training. Disability Support Professional - Must have completed a minimum of 6 hours medical training, 12 hours interpersonal communications and 36 hours technical training.

1. Medical Training:

Subjects: ____________________________ Hours: __________ Dates: _______________

2. Vocational lnterpersonal Communications Training

Subjects: ____________________________ Hours: __________ Dates: ______________

3. Technical Training

Subjects: ____________________________ Hours: __________ Dates: ______________

4. Other special courses - Give description, location of training or school, dates, etc.

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V. Professional Organizations Membership (Related to Disability Evaluation).

1. Name: _________________________ Office Held: __________________ From/To: _____/_____

2. Name: _________________________ Office Held: __________________ From/To: _____/_____

3. Name: _________________________ Office Held: __________________ From/To: _____/_____

I certify that I am currently a member of the N.A.D.E.; that I subscribe to the NADE Code of Ethics; and that the information provided in this application is true, correct and complete to the best of my knowledge.

Signature: ____ Date: ___________

Application must be countersigned by either (1) State Agency Head, State Agency Training Officer or Unit Supervisor; and/or (2) State Unit President or NADE Regional Boardmember.

(1) Signature: __________________________ Title: ___________ Date: ________

(2) Signature: ___________________________ Title: ___________ Date: ________

Please indicate to whom and what address the certificate is to be mailed
(i.e. Applicant, State Agency Head or Training Officer, State Unit President, etc.)

Name: ___________________________________

Address: ____

FOR OFFICE USE ONLY

Application Date: ____________________________________

Date Received in Office: ______________________________

Certification Approved: Yes ___No ___ Date: _________

Certificate Mailed (Date:) ________

Comments: ____

Certification Chair ____________

Form NADE 101 (Updated 06/01/2000)