NATIONAL ASSOCIATION OF DISABILITY EXAMINERS
APPLICATION FOR RECERTIFICATION
(Please print or type)

I. Personal Data
A. Name_____
B. Address_____
_____
C. Daytime Phone number_____
D. E-mail_____
E. Classification: (Disability Professional, Medical Professional, Support Professional)_____

II. Continuing Education: Disability Examiners and Medical Consultants must have completed a minimum of 25 Continuing Certification Credits. Support Professionals must have completed a minimum of 15 Continuing Certification Credits. (1 hour of training= 1 hour of credit)

Course Name	**Date**	**Hours**

I declare that that I am currently a certified member of NADE; I subscribe to the NADE Code of Ethics; and that information provided is true and complete to the best of my knowledge.

Signature Date

Application must be countersigned by either the chapter President, NADE Regional Director, DDS Administrator and/or Conference representative.

(1)_____
NAME TITLE DATE

(2)_____
NAME TITLE DATE

FOR OFFICE USE ONLY

Application Date:_____Date Received:_____

Recertification Approved: ( ) Yes ( ) No Date:_____

Comments:

Certification Chair_____