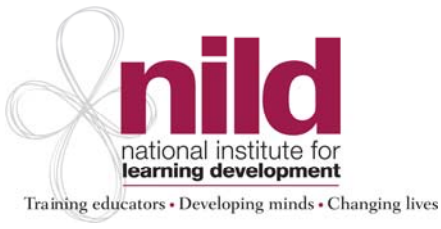


Date Certification Expires (M/D/Y) \_\_\_\_\_

## Application for Professional Certification

| APPLICANT INFORMATION  |                |             |      |
|--|----------------|-------------|------|
| Last Name  | First          | M.I.        | Date |
| Street Address   |                | Apartment # |      |
| City   | State          | ZIP         |      |
| Phone  | E-mail Address |             |      |
| Name of School or Practice   |                |             |      |
| NILD Membership <input type="checkbox"/> School <input type="checkbox"/> Private Practice  |                |             |      |
| GENERAL REQUIREMENTS ( <i>INITIAL</i> CERTIFICATION APPLICANTS ONLY)   |                |             |      |
| Level I  | Year           | State       |      |
| Level II   | Year           | State       |      |
| Level III  | Year           | State       |      |
| PROFESSIONAL DEVELOPMENT REQUIREMENTS FOR ALL APPLICANTS   |                |             |      |
| <i>Attendance at 3 Regional Conferences within the past five years</i>   |                |             |      |
| Year   | State          |             |      |
| Year   | State          |             |      |
| Year   | State          |             |      |
| <i>Complete <b>ONE</b> of the following options:</i> List course, institution and grade achieved   |                |             |      |
| <input type="checkbox"/> Graduate Credit 3 hour course   |                |             |      |
| Please indicate YEAR and STATE   |                |             |      |
| <input type="checkbox"/> FIE Training (indicate level)   |                |             |      |
| <input type="checkbox"/> Rx for Discovery Reading  |                |             |      |
| <input type="checkbox"/> GET Training  |                |             |      |
| NILD EDUCATIONAL THERAPY® EXPERIENCE    400 HOURS MINIMUM  |                |             |      |
| <input type="checkbox"/> Total student contact hours <b>PER YEAR</b> , as supported by progress charts _____   |                |             |      |
| LETTERS OF REFERENCE   |                |             |      |
| School Based Program: <input type="checkbox"/> School Administrator <input type="checkbox"/> NILD program coordinator  |                |             |      |
| Private Practice: <input type="checkbox"/> Parent of current student <input type="checkbox"/> Teacher of current student   |                |             |      |
| SIGNATURE  |                |             |      |
| I certify that my answers are true and complete to the best of my knowledge.   |                |             |      |
| If this application leads to certification, I understand that false or misleading information in my application may result in my loss of professional certification. |                |             |      |
| Signature  |                |             | Date |



Date Certification Expires (M/D/Y) \_\_\_\_\_

## Application for Professional Certification

### APPLICATION FEE

\$250 I understand I will be certified for a period of 5 years from the date my application for certification is approved

*Check enclosed. Please make check payable to NILD in U.S. currency only.*

Charge \$ \_\_\_\_\_ to my:  Visa  MasterCard Expiration Date \_\_\_\_\_

Account Number: \_\_\_\_\_ VCode: \_\_\_\_\_

\_\_\_\_\_  
**Cardholder Name** (please print)

\_\_\_\_\_  
**Signature** (required when using credit card)

\_\_\_\_\_  
Credit Card Billing Address include zip code