

**APPLICATION FORM**

General Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_

Telephone #'s: Home: ( )

Work: ( )

Fax: ( )

Emergency Contact: \_\_\_\_\_

Other Languages Spoken: \_\_\_\_\_

Date: \_\_\_\_\_

SS#: \_\_\_\_\_

License# \_\_\_\_\_

Tax ID#: \_\_\_\_\_

U.S. Citizen: Yes \_\_\_ No \_\_\_

Email Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**PROFESSIONAL INFORMATION**

Discipline: \_\_\_\_\_

**EDUCATION:**

Degree: \_\_\_\_\_

College: \_\_\_\_\_

Year Graduated: \_\_\_\_\_

Graduate Degree: \_\_\_\_\_

College: \_\_\_\_\_

Year Graduated: \_\_\_\_\_

Post Graduate: \_\_\_\_\_

College: \_\_\_\_\_

Year Graduated: \_\_\_\_\_

## **CREDENTIALS**

State License or Certification Held: \_\_\_\_\_

License #: \_\_\_\_\_ Expiration: \_\_\_\_\_

Other Current License Held: \_\_\_\_\_

No: \_\_\_\_\_ Expiration: \_\_\_\_\_

Has your license ever been revoked and/or suspended: Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Specialty Certification Held: SI: \_\_\_\_\_ NDT: \_\_\_\_\_ Other: \_\_\_\_\_

Date Received: \_\_\_\_\_

## **REFERENCES**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Position: \_\_\_\_\_ Position: \_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_

## **EMPLOYMENT HISTORY**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Position Held: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

\_\_\_\_\_

Type of Caseload: \_\_\_\_\_

\_\_\_\_\_

Employment Dates: \_\_\_\_\_

\_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Position Held: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

\_\_\_\_\_

Type of Caseload: \_\_\_\_\_

\_\_\_\_\_

Employment Dates: \_\_\_\_\_

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**TELEPHONE (Home)** \_\_\_\_\_

**PREFERRED WORK LOCATION (County)** \_\_\_\_\_

**EXPERIENCE & EXPERTISE:** In order to match your level of experience and training with a referral request, please provide the following information:

<b>PROFESSIONAL SETTING</b>	<b>PEDS</b>	<b>YEARS EXPERIENCE</b>
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Hospital/Rehab Unit	_____	_____
Hospital/Acute Inpatient	_____	_____
Traumatic Head Injury Unit	_____	_____
Home Health Agency/Home Visits	_____	_____
Psychiatric	_____	_____
Private Practice	_____	_____
School	_____	_____
Early Intervention Program	_____	_____

**AREAS OF SPECIALTY**

**Speech**

Dysphagia/Feeding Disorders	_____
Voice	_____
Dysfluency	_____
Language	_____
Articulation/Phonology	_____
Augmentative Communication	_____
Hearing Impaired	_____
Autism/PDD	_____
Bilingual (Specific Language)	_____
Sign Language	_____
Oral Motor Dysfunction	_____
Myofunctional Treatment	_____
Dyspraxia/Dysarthria	_____

**PT**

Sensory Motor	_____
Orthopedics	_____
Equipment	_____
School-based	_____
* large groups	_____
* small groups	_____
Handling	_____

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**OT**

Sensory Motor	_____
Listening Program	_____
School-based	_____
Handwriting	_____