

PROVIDER CERTIFICATION

Please check the appropriate box:
FAX FORM TO:

Supported Living Coaching
DALE ZINN: 727-217-7046

Supported Employment Coaching
KIM HOUSTON: 941-751-8814

This is to certify that _____ is employed by _____
(Employee Name) (Agency Name)

and meets the minimum qualifications to provide the service indicated above based upon the following criteria:

Education

Bachelor's Degree in _____
(Major)
From _____
(College or University)

OR

Associate's Degree in _____
(Major)
From _____
(College or University)

AND/OR

Work Experience

From: _____ To: _____ # of Hours Worked /Week: _____
(Month/Year) (Month/Year)

Name of Employer: _____

Job Title: _____

Major duties: _____

From: _____ To: _____ # of Hours Worked /Week: _____
(Month/Year) (Month/Year)

Name of Employer: _____

Job Title: _____

Major duties: _____

From: _____ To: _____ # of Hours Worked /Week: _____
(Month/Year) (Month/Year)

Name of Employer: _____

Job Title: _____

Major duties: _____

Individual completing form (please print)

Signature

Title (Owner or Human Resources Officer)

Date

Phone # _____

E-Mail Address: _____

PLEASE NOTE: Enrollment for preservice training will not occur until after this form has been reviewed and approved by APD.