Dysphagia University

NMES for Dysphagia Certification Application to Test

CANDIDATE APPLICATION FOR NDC CHECK LIST

EACH APPLICATION PACKET MUST INCLUDE:

☐ Completed Application form.

The following attachments should be included with the application (see application form for details on proof requirements).

☐ Copy of Certificate of Completion for NMES for Dysphagia competency training program accredited through the Institute for Credentialing Excellence (ICE), which is an American National Standards Institute (ANSI) accredited company.

☐ Proof of attendance and completion of 5 hours of continuing education in the topic of Dysphagia within one year prior to this application. **These continuing education hours must be obtained from ASHA or AOTA approved providers.**

☐ Proof of attendance and completion of 2 hours of continuing education on the topic of NMES for dysphagia within one year prior to this application. **These continuing education hours must be obtained from courses approved by a professional board or provided by an approved provider of a professional board;** can be a PT, OT or SLP modalities course.

☐ Copy of Candidates active license or International equivalent.

☐ Documentation of 250 hours treating using NMES Dysphagia within 1 year prior to this application.

Submit Fees: $50 application fee and exam fee of $300.00 is due at the time of application, made payable to Dysphagia University. We accept Visa, MasterCard, personal check and E-Check. See the NDC Certification Handbook for details and refund policies.

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Name: _____

Please complete all sections of the application. Attach a separate sheet, if additional documentation is necessary. Application information should be clear and concise.

Basic Demographics

Application Date: _____

Professional Title: _____

Home Address: _____ **Home Phone:** _____

Preferred Email: _____

Work

Facility (if applicable): _____

Facility Address: (if more than one facility, please list on a separate page:

_____

_____

City: _____ **State:** _____ **Zip:** _____

Work Phone: _____ **Work Fax:** _____

Work Email: _____

Type of setting (Check all that apply): ☐ Acute Care; ☐ Hospital ☐ OP; ☐ NICU; ☐ Pediatric Clinic;

☐ Private Practice; ☐ Rehab facility; ☐ School; ☐ SNF; ☐ University Clinic

Type of Clients Seen: ☐ Adult ☐ Pediatric ☐ Both

Education

Degree: _____ **Year Granted:** _____ **Granting Institution:** _____

Degree: _____ **Year Granted:** _____ **Granting Institution:** _____

Degree: _____ **Year Granted:** _____ **Granting Institution:** _____

ASHA MEMBER # (OPTIONAL):

CCC ISSUED (MO/YR):

efd

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Application by Section

SECTION I – EDUCATION

- Part 1 - NMES for Dysphagia Competency Training Program (Certificate Course)
- Part 2 – Dysphagia Continuing Education
- Part 3 – NMES for Dysphagia Continuing Education

SECTION II – CLINICAL TREATMENT HOURS

- Part 1 – Documentation
- Part 2 – Verification of Clinical Treatment hours

SECTION III - LICENSE VERIFICATION

- Part 1 – Verification
- Part 2 – Current Status and disciplinary actions

SECTION IV - SIGNATURES

- Part 1 - Payment and Signature

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SECTION I – EDUCATION DOCUMENTATION

Part 1 - NMES for Dysphagia Competency Training Program (Certificate Course)

Candidates must successfully complete a NMES for Dysphagia competency training program accredited through ICE/NCCA. *To help ensure the health, welfare, and safety of the public, ICE created its accrediting body, the National Commission for Certifying Agencies (NCCA) and set the first standards for professional certification programs in the industry.*

- Candidates must pass competency trainings which include applications on the face and anterior portion of the neck and other placements shown to be effective in the treatment of Dysphagia.

- In order to avoid conflict of interest, the course may not be provided by a manufacture or distributor of NMES for Dysphagia devices or electrodes.

- In addition, the training must:
  - Include a minimum of 10 hours of anatomy/physiology
  - Include a minimum of 10 hours of theory, safety, and application
  - Include two or more channel electrode placements
  - Assess and document competency in application and theory
  - Must be an evidence based training to include instruction in current research in the use of NMES for Dysphagia.

Name of course completed:

_____

Date Completed: _____ Location of Course: _____

Course Instructor: _____ Course Provider/sponsor: _____

☐ I understand that I am required to attach of copy of my certificate of completion

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Part 2 – Dysphagia Continuing Education

Candidates must have 5 hours of continuing education (live or online) within 1 year prior to the application, on the topic of dysphagia not including the certificate course. Hours may be obtained by teaching or attending.

Document below continuing education courses attended within the **one year** immediately preceding date of this application. Applicants are required to document a minimum of **5 hours by an approved ASHA and/or AOTA course provider.**

☐ I understand that I am required to attach of copy of my certificates of completion

Name of course completed: _____

Course Dates: _____ Live or Online: _____

Date Completed: _____ Location of Course: _____

Total Course Hours: _____ Course Instructor: _____

Course Provider/sponsor: _____

Name of course completed: _____

Course Dates: _____ Live or Online: _____

Date Completed: _____ Location of Course: _____

Total Course Hours: _____ Course Instructor: _____

Course Provider/sponsor: _____

Name of course completed: _____

Course Dates: _____ Live or Online: _____

Date Completed: _____ Location of Course: _____

Total Course Hours: _____ Course Instructor: _____

Course Provider/sponsor: _____

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Part 3 – NMES for Dysphagia Continuing Education

Candidates must have 2 hours of continuing education (live or online) within 1 year prior to the application on the topic of NMES for dysphagia (approved by a professional board or provided by an approved provider of a professional board; can be a PT, OT or SLP modalities course) (teaching or attending)

Document below continuing education courses attended within the **one year** immediately preceding date of this application. Applicants are required to document a minimum of **2 hours by an approved ASHA and/or AOTA course provider.**

☐ I understand that I am required to attach of copy of my certificate(s) of completion

Name of course completed: _____

Course Dates: _____ Live or Online: _____

Date Completed: _____ Location of Course: _____

Total Course Hours: _____ Course Instructor: _____

Course Provider/sponsor: _____

Name of course completed: _____

Course Dates: _____ Live or Online: _____

Date Completed: _____ Location of Course: _____

Total Course Hours: _____ Course Instructor: _____

Course Provider/sponsor: _____

Name of course completed: _____

Course Dates: _____ Live or Online: _____

Date Completed: _____ Location of Course: _____

Total Course Hours: _____ Course Instructor: _____

Course Provider/sponsor: _____

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SECTION II – DOCUMENTATION OF CLINICAL TREATMENT HOURS

Part 1 – Documentation and Declaration

Candidates must have 250 hours treating with NMES for Dysphagia within one year prior to this application. Candidates should make copies of this form for each facility in which the services were performed.

Eligible hours include any type of NMES for Dysphagia services, including evaluation sessions, treatment and counseling. It is not necessary to attach any other documentation to this log sheet.

Complete the table(s) below with facility name and average hours performed weekly in evaluation and treatment. Then multiply by the number of weeks worked at that facility to total. Use one table per facility worked within the last year. **It is only necessary to report the minimum 250 required hours.**

Facility/ Clinic/ Home Agency #1:								
Facility Address:								
Name of Supervisor: *(If applicable)*								
Supervisor Phone Number:		Supervisor Email:						
☐ **Self-employed** and do not have a supervisor				☐ No longer have contact info for this supervisor				
Average Weekly Evaluation Hours	+	Average Weekly Treatment Hours	=	Total NMES Hours Per Week	X	Number of Weeks Worked	=	Total NMES Hours

Facility/ Clinic/ Home Agency #2:								
Facility Address:								
Name of Supervisor: *(If applicable)*								
Supervisor Phone Number:		Supervisor Email:						
☐ **Self-employed** and do not have a supervisor				☐ No longer have contact info for this supervisor				
Average Weekly Evaluation Hours	+	Average Weekly Treatment Hours	=	Total NMES Hours Per Week	X	Number of Weeks Worked	=	Total NMES Hours

Declaration

☐ By checking the box, I attest that I have accurately reported my clinical hours related to patient evaluation and treatment using NMES for Dysphagia, to the best of my knowledge.

☐ By checking the box, I attest that I achieved _____ total clinical hours related to patient evaluation and treatment using NMES for Dysphagia in the last 12 months.

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SECTION III - LICENSE VERIFICATION

Part 1 – Verification

Licensed Profession: _____

State Issued: _____ Dates Valid: _____to_____

International Equivalent: (Please provide detail)

_____

_____

_____

Part 2 – Current Status and disciplinary actions

	Yes	No
Have you ever had your professional license to practice suspended, revoked or subjected to reprimand?	☐	☐
Have you ever voluntarily surrendered your professional license to practice under any circumstances other than expiration?	☐	☐
Have you ever been subject to disciplinary action by a hospital, State Medical Board, ASHA, or other medical professional organization?	☐	☐
Have you ever been convicted of a misdemeanor or felony?	☐	☐

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You made it! Along with your checklist on page one, please don't forget to:

- ✓ Submit the **$50.00** application and **$300.00** testing fee, payable to "Dysphagia University". Application fee is non-refundable. Personal checks, Visa and MasterCard are accepted.
- ✓ Make and keep a copy of your application packet.
- ✓ Send 1 (one) copy of your complete application packet to:

Dysphagia University
77 Bay Bridge Dr.
Gulf Breeze, FL 32561
Office phone 888-504-4638
info@DysphagiaU.org

CREDIT CARD AUTHORIZATION FORM

Please complete this authorization and return it with your application by fax (xxx) xxx-xxxx or by mail.

Applicant Name: _____

Cardholder Name: _____ Signature: _____

Address: _____

_____

Credit Card Type: ☐ VISA ☐ MASTERCARD

Credit Card Number: _____ _____ _____ _____

Expiration Date: _____ / _____ Billing Zip Code: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Amount Charged: $_____

Apply Amount to: $50 Non-refundable application fee and $300 Testing fee

I fully understand that Dysphagia University, its authorized staff, and their representatives may validate my professional credentials by consulting with the American Speech-Language Hearing Association and/or State Licensing Board or other nationally recognized bodies that maintain automated data files on clinical care professionals.

I certify that the statements/documentation that I have made/provided in this application packet are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that an incorrect or incomplete statement could void continued processing of my application.

_____ _____

Signature of Applicant Date

You will receive an email confirmation that your packet has been received by the office. An electronic account will be created to allow for your 24/7 access to activity regarding your application and testing process.