



SMS Application Materials Checklist

<input type="checkbox"/>	1st page: Contact and demographic info, credit card info (if paying the fee by credit card), indication of special accommodations needed.
<input type="checkbox"/>	2nd page: Education and experience information and attestation signature.
<input type="checkbox"/>	3rd page: Work Verification Form which must indicate: A complete description of your AT direct consumer service related work responsibilities and duties; The time spent in AT direct consumer service in a typical work week; and Supervisor's signature and contact information.
<input type="checkbox"/>	4th page: Good Moral Character Affirmation Form
<input type="checkbox"/>	5th page: Professional Activities and documentation
<input type="checkbox"/>	Application Fee \$250 for 1st time or re-test more than 1 year since last exam attempt; or \$125 for retest within 1 calendar year since last exam. A \$50 processing fee is kept for cancellations

Mail all pages of the completed application with supporting documentation to:

RESNA
1560 Wilson Blvd, Suite 850
Arlington, VA 22209
Phone: 703-524-6686, Fax: 703-524-6630, Email: credentials@resna.org

A confirmation e-mail will be sent to the e-mail address provided on page 1 with instructions on setting up the exam.

QUICK REFERENCE

RESNA: 1560 Wilson Blvd, Suite 850, Arlington, VA 22209-1903 USA 1+703-524-6686 www.resna.org

For application or test site questions: certification@resna.org

For refunds: certification@resna.org

For login: certification@resna.org

For all other general information: certification@resna.org

Prometric: 1501 South Clinton Street, Baltimore, MD 21224, USA www.prometric.com

To schedule, reschedule, or cancel an appointment, call 800-467-9582 Monday-Friday, 8:00 a.m. to 8:00 p.m. Eastern Time (closed holidays)

To report any problems encountered during your testing experience, call 800-853-6769.

For test site closure information: <http://www.prometric.com/sitestatus/default.htm>

For general information: <http://www.prometric.com/TestTakers/ContactUs/email.htm>

For test site issue: <http://www.prometric.com/TestTakers/ContactUs/complaintform.htm>

EXAM PERIODS AND APPLICATION DEADLINES			
Exam	Testing Dates	Applications Accepted Without Late Fee	Applications Accepted With Late Fee
SUMMER 2013			
ATP	July 1 - September 30	April 1 - May 31	June 1-June 15
SMS	July 1 - September 30	April 1 - May 31	June 1-June 15
FALL 2013			
ATP	October 1 - December 31	June 1 - August 31	Sept. 1-September 15
SMS	October 1 - December 31	June 1 - August 31	Sept. 1-September 15
WINTER 2014			
ATP	Jan. 1 - March 31	Sept. 1-November 30	Dec. 1-December 15
SMS	Jan. 1 - March 31	Sept. 1-November 30	Dec. 1-December 15
SPRING 2014			
ATP	April 1 - June 30	Dec. 1- February 28	March 1-March 15
SMS	April 1 - June 30	Dec. 1- February 28	March 1-March 15



SMS Application Form

Application Fee: \$250

Please mail or scan and email your application to RESNA

RESNA

1560 Wilson Blvd, Suite 850

Arlington, VA 22209-1903

Email: certification@resna.org

COMPUTER-BASED TESTING

(Exam is given on an as-needed basis. Please see the Prometric test center page for a list of cities with testing centers.

<http://www.prometric.com/RESNA>)

Application and Test Fee: \$250

- Check
- Money Order
- Master Card
- Visa

Note: We do not accept American Express or Discover Cards

Credit Card Number:

Expiry Date:

Name on Card:

3-Digit Security Code
on back of card:

Billing Address:

Do you require special accommodations?
(If so, please contact office & provide
written medical documentation to support
your request)

- Yes No

If yes:

- Seating accommodation
- Individual proctor or reader needed
- Extended time needed
- Other: contact office immediately to discuss appropriate accommodation

Application Form

1. LAST NAME: (Please print or type clearly)

FIRST NAME & MIDDLE INITIAL

2. PREFERRED MAILING ADDRESS: (this will be listed on the RESNA website directory)

COMPANY/ORGANIZATION

NO & STREET

PO BOX OR APT. NO.

CITY, STATE/PROV, ZIP, POSTAL CODE

3. OFFICE PHONE: (Include area code)

4. FAX: (Include area code)

5. EMAIL ADDRESS (please print clearly)

SMS Application Form

Education and Experience

I AM CURRENTLY LICENSED, CERTIFIED OR REGISTERED, AND IN GOOD STANDING AS A:

- | | |
|---|---|
| <input type="checkbox"/> Professional Engineer | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Assistive Technology Professional |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Rehabilitation Technology Supplier - CRTS® |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy Assistant | <input type="checkbox"/> No license, certificate or registration listed above |

MY PRIMARY ROLE IN SEATING AND MOBILITY:

- | | |
|---|---|
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Educator | <input type="checkbox"/> Physical Therapy Assistant |
| <input type="checkbox"/> Engineer | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Manufacturer | <input type="checkbox"/> Rehabilitation Technology Supplier |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Rehab Supplier Technician |
| <input type="checkbox"/> Occupational Therapy Assistant | <input type="checkbox"/> Other _____ |

PRIMARY PROFESSIONAL SETTING:

- | | |
|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Government |
| <input type="checkbox"/> Medical rehabilitation facility | <input type="checkbox"/> Veteran's administration |
| <input type="checkbox"/> Outpatient clinic | <input type="checkbox"/> Vocational rehabilitation |
| <input type="checkbox"/> Assisted living | <input type="checkbox"/> State AT act program |
| <input type="checkbox"/> Long term care | <input type="checkbox"/> Supply |
| <input type="checkbox"/> Manufacturing | <input type="checkbox"/> DME supplier |
| <input type="checkbox"/> Production research or design | <input type="checkbox"/> Complex rehab supplier |
| <input type="checkbox"/> Sales | <input type="checkbox"/> Education |
| <input type="checkbox"/> Education | <input type="checkbox"/> K-12 |
| <input type="checkbox"/> Private community based service | <input type="checkbox"/> Higher Education |
| <input type="checkbox"/> Other _____ | |

EDUCATIONAL LEVEL (Check only one):

- Master's Degree or higher in Special Education
- Master's Degree or higher in a Rehab Science
- Bachelor Degree in Special Education
- Bachelor Degree in a Rehab Science
- Bachelor Degree or higher in a Non-Rehab Science
- Associate Degree in a Rehab Science
- Associate Degree or higher in a Non-Rehab Science
- HS Diploma or GED

TOTAL NUMBER OF YEARS EXPERIENCE IN ASSISTIVE TECHNOLOGY: _____

Signature _____

Date _____



Verification of Work Experience in Seating and Mobility Service Delivery

SECTION I: To be completed by applicant.

APPLICANT'S NAME: _____

SUPERVISOR'S NAME: _____

ORGANIZATION: _____

TELEPHONE: _____

ADDRESS: _____

DATES OF EXPERIENCE /EMPLOYMENT: _____

SECTION II: To be filled out and signed by Applicant:

Seating and Mobility related service is defined as those services that are provided in-person to consumers and others related to or working with consumers in various settings. The 1000 hours can be acquired at any time in your professional experience, and they include evaluation and assessment, product trial, fitting, modifications, troubleshooting, training, and related documentation.

The following services related to seating and mobility would not be applicable for inclusion in the total of 1,000 hours. This list is not all inclusive. The applicant may appeal an adverse decision on work verification to the Professional Standards Board.

1. Customer service, scheduling, and/or paperwork processing of seating and mobility orders
2. Billing, collections and/or claims processing of seating and mobility products
3. Information gathering and sharing via telephone or internet only.

Describe your weekly job responsibilities in seating and mobility related service.	Average hrs/ week	# of weeks worked

Applicant Signature _____

Date _____

Please provide a professional contact to verify experience in the event of an audit:

Name _____

Phone _____



Good Moral Character Affirmation Questions

Please answer the following questions in order to address any issues that may be harmful to the public or inappropriate to the profession. A "yes" answer will not necessarily result in a denial of certification. However, please fully disclose any relevant information so that the RESNA Professional Standards Board can make an informed evaluation and decision.

Have you ever been convicted of, pled guilty or no contest to, been acquitted by reason of mental disease or defect, entered into a diversion in lieu of prosecution, or had adjudication withheld on a felony charge in any legal jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been convicted of, pled guilty or no contest to, been acquitted by reason of mental disease or defect, entered into a diversion in lieu of prosecution, or had adjudication withheld on a misdemeanor involving theft, fraud, bribery, corruption, perjury, embezzlement, solicitation, dishonesty, physical harm or threat of physical harm to the person or property of another or substance abuse in any legal jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been subject to an adverse civil or administrative judgment for theft, fraud, corruption, embezzlement, solicitation, dishonesty, substance abuse, or other acts of moral turpitude (any offense that calls into questions the integrity or judgment of your actions)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently or ever been subject to disciplinary action (i.e. sanctioned, reprimanded, suspended, or restricted) by any professional body, association, licensing authority, board or certifying association of which you were or are a member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been discharged from employment for theft, fraud, corruption, embezzlement, solicitation, dishonesty, substance abuse, or other acts of moral turpitude (any offense that calls into questions the integrity or judgment of your actions)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Note: No applicant will be denied solely on the grounds of conviction of a criminal offense. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense will be considered.

I, the undersigned, certify the above and accompanying eligibility information is correct. I also acknowledge and accept the regulations of the RESNA Professional Standards Board and recognize this Board as the sole and only judge of my qualifications to receive and retain a certification issued on behalf of the Board and to have my name published in any list or directory in which certified, or de-certified, individuals are listed. I pledge to follow the RESNA Code of Ethics and RESNA Standards of Practice in my work with assistive technology.

<input type="checkbox"/>	I declare and affirm that the statements made in this certification application are complete and correct, understand that I may be subject to a random audit and a background check and that any false or misleading information may be cause for denial or disciplinary action.
<input type="checkbox"/>	To the best of my knowledge and belief I am in compliance with the RESNA Code of Ethics and Standards of Practice.

Signature _____

Date _____



SMS Application Form: Professional Activities

Professional Categories (Choose two.)

Please select TWO types of professional activities from the 7 professional categories below that you have completed in the past 5 years. No more than two of the seven are needed. SEE APPENDIX A for a detailed list of professional activities within each category listed below. Note that the full time commitment described must be met to check off that category (no partial credits are awarded).

Professional Categories (Choose two.)

- Continuing education (1 CEU in seating and mobility-related services).
Note: CRTS designation in good standing from NRRTS fulfills this requirement
- Presentations/formal instruction
- Mentoring/supervision
- Client service delivery
- Advocacy
- Leadership
- Publications

Activity 1 Description

Identify 1 activity from the appendices for the first professional category chosen.

Activity 1 Supporting Evidence Attached

Activity 2 Description

Identify 1 activity from the appendices for the second professional category chosen.

Activity 2 Supporting Evidence Attached



Appendix A

Select **TWO** of the seven professional activity categories and submit evidence for **ONE** activity from each category selected.

Professional Activity Category (within past 5 years)	Evidence submitted (please attach)
Category 1. Client Service Delivery	
Activity a. Submission of clinical case study (does not have to be published); OR	See Appendix B
Activity b. Direct work with clients or participants who use seating/mobility devices in research study; OR	Institutional Review Board (IRB) approval, form outlining roles/responsibilities, timeline, commitment, project abstract.
Activity c. Direct work with clients in a teaching/coaching capacity (e.g. wheelchair sports).	See Appendix C
Category 2. Advocacy – Community, Client, Profession	
Activity a. Lobby local, state and/or federal legislative or regulatory agencies to influence change (i.e. CELA advocacy day); OR	See Appendix C
Activity b. Implement an advocacy activity for consumers, organizations and/or providers outside of the professional community to increase awareness of seating and mobility technologies (i.e. education, letter-writing campaign, etc); OR	See Appendix C
Activity c. Expert witness or participating in testimony (written or verbal)	See Appendix C



Appendix A

Continued

Professional Activity Category (within past 5 years)	Evidence submitted (please attach)
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Category 3. Mentoring/Supervision in Seating and Wheeled Mobility	
Activity a. Formal fieldwork supervision (minimum 4 week period); OR	See Appendix D
Activity b. Direct on-the-job training/supervision (minimum 4 week period).	See Appendix D

Category 4. Presentations/Formal Instruction	
Activity a. Formal conference presentations at local, state, national, and international conferences; OR	Brochure, conference URL, acceptance letter
Activity b. Formal workshop presentations of at least four hours; OR	Brochure, flyer acceptance letter
Activity c. Formal class instruction (at least 4 hours) of college students; OR	Letter on university letterhead detailing instruction, time spent
Activity d. Author on-line education (minimum of 0.4 CEU to be awarded for the course).	Proof as instructor, URL



Appendix A

Continued

Professional Activity Category (within past 5 years)	Evidence submitted (please attach)
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Category 5. Learning/Continuing Education	Evidence submitted (please attach)
<p>Activity a. Attend educational forums on seating and mobility and/or other topic areas indirectly related to this area (i.e., transportation, wound care, medical/therapeutic intervention, etc)</p> <ul style="list-style-type: none"> · Local, state, national or international conferences · Focused topic workshops provided by individuals, organizations or manufacturers · On-line course 	<p>Certificate of attendance/completion showing CEUs earned, title, dates. CEUS must come from an IACET-approved provider or accredited university</p>
<p>Activity b. Successfully complete a relevant academic-credited course.</p>	<p>Transcript</p>

Category 6. Publications	
<p>Activity a. Publish in a peer-reviewed journal on topic areas related to seating and mobility; OR</p>	<p>Reference and abstract</p>
<p>Activity b. Author or co-author book chapters related to seating and mobility or related areas; OR</p>	<p>Reference and abstract</p>
<p>Activity c. Serve as a reviewer for a peer-reviewed journal/publication.</p>	<p>Formal letter as reviewer</p>



Appendix A

Continued

Professional Activity Category (within past 5 years)	Evidence submitted (please attach)
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Category 7. Leadership and Service	
<p>Activity. Provide seating and mobility-related service to individuals, groups, local or national associations or organizations. Leadership/Service may include, but is not limited to participation in an activity such as:</p> <ul style="list-style-type: none"> · Surveyor for a deemed accrediting organization · Conference program or research-award review · Serving on not-for-profit disability-oriented board of directors · International outreach program · Certifier for a sporting event · Professional committees · Leadership positions within a professional organization · Expert panel participation · Standards development <p>Other (please describe)</p>	<p>See Appendix C , and explain how it relates to seating and mobility</p>



Appendix B

Case Study Overview

You will be presenting a client with seating, positioning, and mobility needs that has already been assessed and intervention completed. Include detailed information in writing, as relevant, in the following categories:

- I. Background and problem identification related to the individual, the environment, and the technology
 - a. pertinent medical history
 - b. physical abilities and needs
 - c. functional abilities and needs
 - d. seating and mobility abilities and needs
 - e. home accessibility
 - f. currently used assistive devices
 - g. environmental considerations

- II. Feature match - choices considered to meet identified goals and needs, pros and cons/tradeoffs

- III. Solution Selection - clinical rationale to justify necessity (medical, vocational, educational, recreational) of chosen features

- IV. Implementation and follow-up (specify goals, services and referrals following delivery and fitting)



Appendix C
Documentation of Professional Activity Form
(copy as needed and use 1 per activity to verify eligibility)

Name: _____

1. Evidence attached: Transcript Confirmation on letterhead Certificate Other
(as appropriate)

2. Type of professional activity submitted:

- Advocacy
 - Lobbying
 - Community Activity
 - Expert witness/testimony

- Direct work with clients in teaching/coaching capacity (not related to delivery, fitting)

- Leadership and Service

3. Describe activity as it relates to seating and mobility:

4. Amount of time spent in activity (hours): _____

5. Date(s) of activity: _____

6. Name of contact related to the activity (for audit): _____

7. Contact phone # (in case of audit): _____



Appendix D
Documentation of Mentoring/Supervision Form

Your Name: _____

Name of Person supervised: _____

Dates of supervision: _____

1. Evidence attached: Confirmation on letterhead Certificate Other
(as appropriate)

2. Type of professional activity submitted:

Formal fieldwork supervision (student)

Direct on-the-job training:

3. Describe activities and time spent related to seating and mobility:

4. Total amount of time spent in activity (hours): _____

5. Name of contact related to the activity (for audit): _____

6. Contact phone # of trainee or university contact (in case of audit): _____

Signature of person trained: _____

