

2017 ATP Application



Eligibility Requirements

Before taking the exam, all candidates must first satisfy the Work Experience and Education/Training criteria. Please refer to the requirements on Page 2 of the application.

RESNA 2017 ATP Exam Schedule

Test Window	Testing dates	Applications accepted	Applications accepted with late fee of \$50
Winter/Spring	March 13 – June 30	January 1 – February 28	March 1 - March 15
Summer	July 1 – September 30	April 1 – May 31	June 1 – June 15
Fall	Oct 1 – December 31	June 1 – August 31	Sept 1 – Sept 15

RESNA ATP Application Checklist

<input type="checkbox"/> Page 1	Contact, exam scheduling, and payment information. <ul style="list-style-type: none">• If you are paying by check or money order, please attach your payment.
<input type="checkbox"/> Page 2	Eligibility Requirements Table / Education <ul style="list-style-type: none">• Include a copy of diploma/GED or transcript• Depending on your education level, you may be required to submit documentation of assistive technology education/training (See table under “Eligibility Requirements”).
<input type="checkbox"/> Pages 3, 4, 5	Work Experience form with complete description of your AT direct consumer service-related work responsibilities/duties and time spent in these activities (Page 3) Employer Verification of work experience, signature and contact information. (Page 4) If you are a company owner or have no supervisor, you must complete the Reference Verification form (3 copies) on page 5 in place of Page 4.
<input type="checkbox"/> Page 6	Good Moral Character Affirmation Form
<input type="checkbox"/> Pages 7-8	Applicant Profile Information

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

RESNA
1700 North Moore Street Suite 1540
Arlington, VA 22209-1903
Fax: 703-524-6630; Email: certification@resna.org

To avoid duplicate charges on your credit card, submit your application **just once**.

Within three weeks of receiving your application, if RESNA determines that you have satisfied the eligibility criteria, then RESNA will email you a confirmation notice with instructions for scheduling your exam with Prometric.

For questions, please contact RESNA at 703-524-6686 or certification@resna.org

Contact Information

2017 ATP Exam Application



Name: _____

Note: Please write your name exactly as it appears on your state-issued ID. All candidates must present their ID for admittance into the Prometric test center. If on your ID, your name appears differently from how you've written it above, you will be denied entry into the test center.

Home Address: _____

Home Address Line 2: _____

City: _____ State/Province: _____ Zip/postal: _____ Country: _____

Phone number: _____ Cell Phone number: _____

Organization: _____ Job title: _____

Business Address: _____

Business Address Line 2: _____

City: _____ State/Province: _____ Zip/postal: _____ Country: _____

Business phone number: _____ Fax number: _____

Preferred address for USPS communications from RESNA: home business

Preferred Email Address: _____

(Note: RESNA will send exam scheduling instructions to this email address)

Exam Scheduling and Payment of \$500 exam fee

2017 Test window: Winter/Spring Summer Fall

Do you require special accommodations? no yes (explain reason, and attach medical documentation):

Payment (\$500):

Check/Money order

Credit Card Number: _____ Expiration date: _____ Sec. code: _____

Name on Card: _____

Billing address: _____

Signature: _____ Date: _____

For RESNA use only:

App received: _____ Reviewed: _____ Final Approval: _____ Approved by: _____

Contact & payment info: _____ Email for missing docs: _____ Email received: _____

Diploma/Transcript: College: _____ High school / GED: _____ CE: 10 20 30 Work Verification Complete: _____

Update database: _____ Set eligibility w/ Prometric: _____ Email conf for testing: _____

Accommodations needed: _____ Comments: _____

Eligibility Requirements: Education/Training and Work Experience



<u>Level of formal education:</u>	<u>Work Experience Req.***:</u>	<u>Additional Education:</u>
<input type="checkbox"/> Master's Degree or higher in Special Education	1000 hours in 6 years	
<input type="checkbox"/> Master's Degree or higher in Rehab Science*	1000 hours in 6 years	
<input type="checkbox"/> Bachelor's Degree in Special Education	1500 hours in 6 years	
<input type="checkbox"/> Bachelor's Degree in Rehab Science*	1500 hours in 6 years	
<input type="checkbox"/> Bachelor's Degree in Non-Rehab science	2000 hours in 6 years	10 hours AT training**
<input type="checkbox"/> Associates Degree in Rehab Science*	3000 hours in 6 years	
<input type="checkbox"/> Associate Degree in Non-Rehab Science	4000 hours in 6 years	20 hours AT training**
<input type="checkbox"/> High School Diploma or GED	6000 hours in 10 years	30 hours AT training**

*A degree in Rehabilitation Science is defined as one of the following:

- Assistive technology
- Vocational rehabilitation
- Low vision rehabilitation
- Audiology
- Medicine
- Nursing
- Physical therapy
- Occupational therapy
- Speech language pathology
- Ergonomics or related curricula
- Engineering (biomedical, clinical, or rehabilitation)
(Contact RESNA to ask about other related degrees)

Education/Training

Degree Program Name: _____ Date conferred: _____

Institution Name: _____

City: _____ State/province: _____ Country: _____

You must submit a copy of your GED/diploma or transcript that shows the degree program name and conferral date.

****If you have not completed a degree in Rehab Science or Special Education**, then you must submit documentation of additional assistive technology (AT) training. At least half of the requirement must be met by Continuing Education Units (CEUs) approved by an IACET-accredited organization, accredited university or professional society. The remaining hours may be met by Continuing Education Credits (CECs) or contact hours from lectures and seminars. Documentation must include your name, the course name, date, and length (hours), the number of CECs/CEUs awarded, and the signature of the instructor or training administrator. This training must be completed within the same timeframe as your work experience requirement (the past 6 years or the past 10 years, depending on your level of education).

Examples of appropriate education / training:

- Evaluation and assessment procedures for AT
- In depth AT product training
- Diagnoses and treatment as they relate to AT
- Public policy/legislation related to AT
- AT reimbursement and funding
- Clinical practice related to AT
- AT-related research
- Professional ethics

Examples of education / training activities that **do not** meet requirements:

- Coursework or credits that are not AT-related
- Attending the same course multiple times
- Product training or demonstration without full documentation of date, time, topic, presenter

Work Experience

*** The work experience requirement must be satisfied with work hours dedicated to direct (in-person) consumer-related assistive technology (AT) service provision. A more detailed definition appears on the following page.

Please note that the following activities are not considered to be AT service-related, and therefore cannot be applied towards the requirement (note: this list is non-inclusive):

- Customer service, scheduling, information gathering and/or paperwork processing of assistive technology orders
- Billing, collections and/or claims processing of assistive technology products/services
- Professional development, didactic teaching or instructing providers/teachers on topics of assistive technology, which does not include consumer/student contact
- Research and/or development, which does not include consumer/student contact
- Telecommunication relay services
- Technical repair and maintenance of AT products with no direct consumer contact/interaction

Work Experience in Assistive Technology (to be completed by the applicant)



Submit a separate Work Experience Form for each position that you are submitting to meet the work experience requirements indicated on Page 2. For each “Work Experience” form you complete, you must also submit a completed Employer Verification form (Page 4). EXCEPTION: If you are the business owner, president, or CEO, OR you are a supervisor who has no other management staff at your workplace able to verify your work experience, then you must instead submit three completed copies of the Reference Verification (page 5) with this Work Experience Form.

Section I: To be completed by applicant

Applicant’s name: _____ Position title: _____

Company Name: _____

Company Address: _____

Dates of Employment: From: _____ To: _____ Average Hours per week: _____

Supervisor Name: _____ Supervisor Phone number: _____

Direct (in-person) consumer-related assistive technology (AT) service provision includes, but is not limited to:

- Evaluations, assessments and other direct-to-consumer/student services (needs assessment; physical, functional, and/or sensory assessments; educational assessments; site assessments; simulations and product trials)
- Fitting, adjustment and readjustment services (fine tuning of equipment to meet the consumer/student’s needs and reflect changes in the consumer/student’s status)
- Implementation and training for consumers/caregivers or students/support personnel (training in use of AT; strategies to maximize function and interface with environment(s) of use; instruction in use/maintenance of AT)
- Product development that involves direct consumer participation

For this position, calculate how much of your time was spent providing **direct consumer-related AT services**:

$$\frac{\text{_____}}{\text{number of hours per week dedicated to AT service provision}} \times \frac{\text{_____}}{\text{number of weeks per year}} = \frac{\text{_____}}{\text{hours per year}}$$

Describe <u>your</u> weekly job responsibilities in direct consumer-related AT service provision.	Average hours per week	# of weeks worked per year

Applicant’s signature: _____ Date: _____

Employer Verification of Work Experience in Assistive Technology Service Delivery



For each Work Experience Form (page 3) you complete, you must also submit this completed Employer Verification form. **EXCEPTION:** If you are the business owner, president, or CEO, OR you are a supervisor who has no other management staff at your workplace able to verify your work experience, then you must instead submit three completed copies of the Owner/Supervisor Verification (page 5) with your Work Experience Form(s).

SECTION I: *To be completed by applicant.*

Applicant's name: _____ Position title: _____

Company Name: _____

Company Address: _____

Dates of Employment: From: _____ To: _____.

SECTION II: *To be completed and signed by Supervisor or Employer:*

Supervisor's name: _____ Phone number: _____

Dates for which you oversaw the applicant's work: from: _____ to: _____

Your job title during the time you oversaw the applicant's work: _____

In what way were you responsible for supervising the applicant's work?

To verify the applicant's work experience, please write a detailed description of the applicant's job responsibilities related to providing assistive technology services directly (in person) to consumers. Then return this document to the applicant for submission.

Applicant's total number of hours in a typical week dedicated to the responsibilities above: _____

Dates of your employment with the company above: from: _____ to: _____

If you are no longer with the company above, please provide your current company name and address:

Verifier's current Job title: _____

Verifier's signature: _____ Date: _____

Reference Verification of Work Experience in Assistive Technology Service Delivery



Use this form ONLY if you are the business owner, president, or CEO, OR you are a supervisor who has no other management staff at your workplace able to verify your work experience.

Please make **THREE** copies of this form to provide to individuals who can serve as references to verify your work experience over the time needed to meet the eligibility requirements.

SECTION I: To be completed by *applicant*.

Applicant's name: _____ Position title: _____

Company Name: _____

Company Address: _____

Dates of Employment: From: _____ To: _____.

SECTION II: To be filled out and signed by the *reference*:

I attest that I have worked with the applicant _____, and have known
candidate name

him/her in a professional capacity, working in AT direct consumer-related services for the period from

_____ to _____.
date date

The applicant has worked with me to provide the following assistive technology services:

My professional relationship with the applicant is as follows:

My background in assistive technology is:

Name of reference _____ Phone number: _____

Current Job Title _____

Organization Name _____

Organization Address _____

Dates of employment: from: _____ to: _____

Reference's signature _____ Date _____

Good Moral Character Affirmation



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 decertified, 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: _____

Applicant Profile Information



What is your primary professional setting (Check only one):

- Academic institution (post-secondary education)
- Academic institution (primary or secondary education)
- Acute care hospital
- Community-based center, i.e. independent living center, AT specialty center
- Complex Rehabilitation Technology (CRT) supplier/provider
- Durable Medical Equipment (DME supplier/provider)
- Health system or hospital-based outpatient facility or clinic
- Industry/Manufacturer
- Inpatient rehab facility
- Government funded agency
- Patient's home/home care
- Private outpatient office or private practice
- Research center
- Retail AT supplier
- Skilled nursing facility/long term care facility
- Other, specify:

AT Practice Specialty Area (Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Architectural Accessibility & Universal Design | <input type="checkbox"/> Prosthetics |
| <input type="checkbox"/> Cognition & Learning | <input type="checkbox"/> Recreation, Leisure & Sports |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Seating, Positioning & Mobility |
| <input type="checkbox"/> Computer Access & Applications | <input type="checkbox"/> Tele-rehab & Tele-monitoring |
| <input type="checkbox"/> Employment & Workplace Modifications | <input type="checkbox"/> Transportation & Driving |
| <input type="checkbox"/> Environmental & Personal Aids for Daily Living | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Other, specify: |
| <input type="checkbox"/> Orthotics | <input type="checkbox"/> No AT practice specialty |
| <input type="checkbox"/> Personal Robotics | |

Years worked in your professional area?

- 2 years or less 3 to 6 years 7 to 10 years 11 years or more

Most Relevant Academic/Professional Training (Check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Assistive Technologist | <input type="checkbox"/> Educator, Special Ed | <input type="checkbox"/> PT Assistant |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Industrial Engineer | <input type="checkbox"/> Prosthetist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Mechanical Engineer | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Biomedical Engineer | <input type="checkbox"/> Mechanical Maintenance | <input type="checkbox"/> Rehabilitation Engineer |
| <input type="checkbox"/> Building Trades | <input type="checkbox"/> Nurse | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Computer Science | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Speech & Language Pathologist |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> OT Assistant | <input type="checkbox"/> Technician |
| <input type="checkbox"/> Electrical Engineer | <input type="checkbox"/> Orthotist | <input type="checkbox"/> Other, specify: |
| <input type="checkbox"/> Ergonomist | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Educator, General Ed | <input type="checkbox"/> Physical Therapist | |

Highest Education Level Achieved

- | | |
|---|---|
| <input type="checkbox"/> HS Diploma or GED | <input type="checkbox"/> Masters -- MA, MS |
| <input type="checkbox"/> Associate - AA, AS | <input type="checkbox"/> Doctorate -- MD, PhD, EdD, ScD, DO, PTD, OTD, JD |
| <input type="checkbox"/> Bachelor - BA, BS | <input type="checkbox"/> Other, specify _____ |

Are you a student presently?

- Yes No

(continued on next page)



What is your primary role in the AT field? (Check only one)

- Service provider (e.g., evaluates users' abilities and needs; identifies and specifies AT and environmental solutions; manages service delivery processes; trains in the use of technology)
- Technology supplier (e.g., assesses user and devices; selects, orders, configures, customizes, designs, fabricates and sells commercial and non-commercial AT devices)
- Manufacturer (e.g., designs, develops, tests, packages, distributes, resells and markets commercial AT devices and software)
- Educator of AT professionals
- Educator (e.g. pre-school, K-12, university, trade, etc.)
- Researcher
- Resource provider (e.g. information and referral; demonstration, loan or reuse programs; advocacy; funder, etc.)
- Other, specify _____

What other roles do you perform in the AT field? (Check all that apply)

- Service provider (e.g., evaluates users' abilities and needs; identifies and specifies AT and environmental solutions; manages service delivery processes; trains in the use of technology)
- Technology supplier (e.g., assesses user and devices; selects, orders, configures, customizes, designs, fabricates and sells commercial and non-commercial AT devices)
- Manufacturer (e.g., designs, develops, tests, packages, distributes, resells and markets commercial AT devices and software)
- Educator of AT professionals
- Educator (e.g. pre-school, K-12, university, trade, etc.)
- Researcher
- Resource provider (e.g. information and referral; demonstration, loan or reuse programs; advocacy; funder, etc.)
- Other, specify _____

Professional Credentials/Licenses Held (Check all that apply)

- CO CRC MD/DO PA PTA Other:
- CP CRTS OT PE RET
- CPE LCSW OTA PT RRTS

Member Organizations Other than RESNA (Check all that apply)

- AAA APTA BMES NCART
- AAHomecare ASHA CTF NRRTS
- ACM ASME HFES TASH
- AOTA ATA IEEE Other:

Self-Description (Voluntary)

- African American Asian American Chicano/Mexican American Spanish American
- American Indian Caucasian Puerto Rican Other