



Application for ADHD Certified Rehabilitation Services Provider (ADHD-RSP)

Date: _____

Name (as it appears on your license): _____

Mailing Address: _____

City/State/Zip/Country: _____

Phone: _____

Email Address: _____

I attest to the following (please initial each):

____ I am a State or Nationally licensed (or equivalent outside the U.S.) professional as outlined in Criterion 1.1 of the Certification Standards

____ My professional license is current and in good standing as outlined in Criterion 1.2 of the Certification Standards

____ I am covered by current malpractice insurance (individual or under an agency) that meets or exceeds the requirements as outlined in Criterion 1.2 of the Certification Standards

____ I have completed the required 30 education hours of ADHD Assessment and Treatment as outlined in Criterion 2.1 of the Certification Standards

____ I have conducted at least 200 contact hours treating ADHD-diagnosed clients as outlined in Criterion 3.0 of the Certification Standards

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted.

I understand that information submitted with this application may be verified for accuracy by the Institute of Certified ADHD Professionals. I also agree to contact the Institute of Certified ADHD Professionals if I no longer meet the requirements to be a Certified ADHD Rehabilitation Services Provider.

Signed: _____ Date: _____