EVERGREEN
CERTIFICATIONS

Application for Certified Autism Spectrum Disorder Clinical Specialist (ASDCS)

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 the Evergreen Certifications Code of Ethics

____I have completed the required 18 education hours as outlined in Criterion 2.1 of the Certification Standards

____I have conducted at least 100 clinical contact hours with clients with Autism Spectrum Disorder traits and/or diagnosis 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 Evergreen Certifications. I also agree to contact Evergreen Certifications if I no longer meet the requirements to be a Certified Autism Spectrum Disorder Clinical Specialist.

Signed: _____ Date: _____