RIVERWOOD CENTER'S
AUTISM PROVIDER'S
LICENSE / CERTIFICATION VERIFICATION APPLICATION

INSTRUCTIONS: Print or type all responses. Attach additional sheets if there is insufficient space on this form for your response. Return your completed application to the Riverwood Center, Attention: Sara Schaeffer, P.O. Box 547, Benton Harbor, MI 49023.

TYPE OF PROVIDER CERTIFICATION REQUESTED

_____ **BCaBA** _____ **BCBA** _____ **BCBA-D**

CLINICIAN INFORMATION
PLEASE ATTACH CLINICIAN RESUME AND NPI NUMBER

CLINICIAN'S NAME: _____

DOB: _____ NPI Number: _____

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

LICENSE INFORMATION
List all professional licenses.
PLEASE ATTACH VALID COPIES OF ALL LICENSES

1. Michigan License #: _____ Exp. Date: _____
   Type of License: _____ Is the license Current: _____Yes _____No
   State: _____ License #: _____ Exp. Date: _____

2. Other License #: _____ Exp. Date: _____
   Type of License: _____ Is the license Current: _____Yes _____No
   State: _____ License #: _____ Exp. Date: _____

CERTIFICATION INFORMATION
List all professional licenses.
PLEASE ATTACH VALID COPIES OF ALL CERTIFICATIONS

1. Certification Level: _____ Exp. Date: _____
   Certification Number: _____

2. Certification Level: _____ Exp. Date: _____
   Certification Number: _____

EDUCATION INFORMATION

PLEASE ATTACH VALID COPIES OF ALL TRANSCRIPTS

College/University: _____
Complete address: _____
_____
_____
Dates attended: _____ Degree received: _____
Major:_____

College/University: _____
Complete address: _____
_____
_____
Dates attended: _____ Degree received: _____
Major: _____

ACKNOWLEDGE & AGREE

By signing this, I give consent for the verification of the information provided in this application. I agree to notify Riverwood Center of any changes to my professional licensure and /or certification status. I will keep a copy of this application for my records.

_____ _____
Signature of Applicant **Date**