



Please print or type

Name (First, MI, Last) \_\_\_\_\_

Preferred first name \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home email \_\_\_\_\_ Work email \_\_\_\_\_

Please send correspondence to: \_\_\_ Home \_\_\_ Work

Employer \_\_\_\_\_ Unit \_\_\_\_\_

Work mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DDNA Membership No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

DDNA Certification No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

Employment: Full-Time Part-Time
Licensure: RN NP (circle all that apply)

Credentials (Please print or type clearly on the line below, as they will appear on your certificate exactly as they are listed. E.g.; "Stacey R. Smith, RN, MSN, CDDN.")

\_\_\_\_\_

Please circle all that apply:

Population served:

Birth to three (1)

Pre-school age (2)

School age (3)

Adult (4)

Geriatric (5)

Other (6) \_\_\_\_\_

Practice setting:

Early intervention program (a)

Day treatment program (b)

Residential program (c)

Workshop (d)

Consultant (e)

Other (f) \_\_\_\_\_



The nurse who practices with a specialty in developmental disabilities:

- Contributes significantly to the services provided to individuals with a developmental disability with respect for the uniqueness of the individual and human dignity;
- Accepts responsibility for developing expertise in developmental disabilities nursing practice through self-development and continuing education;
- Recognizes the rights of individuals with a developmental disability, acts as an advocate, and strives to ensure that the rights are protected;
- Promotes and maintains a safe environment which enhances the physical, emotional, and spiritual well-being of the individual;
- Maintains confidentiality at all levels in accordance with professional standards of practice, agency guidelines and state and federal law;
- Makes contributions from the nursing perspective, while recognizing the collaborative nature and unique role of the interdisciplinary team in providing quality services for individuals with developmental disabilities;
- Commits to making contributions to the development of innovative ideas for nursing practice in the field of developmental disabilities;
- Serves as a resource to prepare other team members, including direct support professionals, to provide quality health supports to people with developmental disabilities.

.....

*I am aware of my professional responsibility to maintain appropriate behavior. I agree to strive to abide by the above code of ethics while providing nursing services to individuals with developmental disabilities.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Nursing license number \_\_\_\_\_ State \_\_\_\_\_





Certification Renewal Application

Applicant's name: \_\_\_\_\_

Name of institution/employer: \_\_\_\_\_

Website address (see instructions below): \_\_\_\_\_

Applicant's job title for this verification form: \_\_\_\_\_

Certification expiration date: \_\_\_\_\_

The following is to be completed by the applicant's supervisor:

Total number of hours worked by the employee (listed above) during the two year period before the certification expiration date (written above): \_\_\_\_\_

I affirm that the information on this form is true and correct to the best of my knowledge.

Supervisor's signature: \_\_\_\_\_

Supervisor's name (printed): \_\_\_\_\_

Position: \_\_\_\_\_

Company/Unit/Program: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Signature date: \_\_\_\_\_

Instructions:

- 1. Submit one completed employment verification form and job description for each position, period of employment, and/or facility/program. (NOTE: full time employment = 2080 hours per year)
2. Job descriptions must accompany this form and be specific to Developmental Disabilities Nursing practice. Generic job descriptions are not acceptable.
3. Verification that facility/agency provides services to individuals with I/DD: If you provide the website address for your facility, it is not necessary to include printed brochures, program outlines, or descriptions of the agency or facility. If there is no website, please include a brochure, program outline, or description of the agency or facility.
4. Do not submit forms with altered dates or hours.
5. Originals of completed forms must be submitted.
6. Only original signatures will be accepted.