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DISTRICT SPECIALTY CERTIFICATION FORM

Complete this form to certify a Provider's Specialty has been credentialed by a District.

Add/Modify Specialty

Complete this section when adding a new provider and their associated specialty or specialties. Complete a separate form for each provider.

❑ **Agency Provider** ❑ **Independent Provider** ❑ **District Employee**

District Name (if applicable): _____

Provider First Name: _____ MI: ____ Last Name: _____

Early Intervention Specialty

Please indicate all specialties which apply and the date the specialty became effective.

Add	Modify	Delete	Specialty	Effective Date
❑	❑	❑	Assistive Technology Provider	/ /
❑	❑	❑	Audiologist	/ /
❑	❑	❑	Counseling – Licensed Professional	/ /
❑	❑	❑	Dietitian	/ /
❑	❑	❑	Early Intervention Assistant	/ /
❑	❑	❑	Early Intervention Specialist	/ /
❑	❑	❑	Early Interventionist	/ /
❑	❑	❑	Family Member	/ /
❑	❑	❑	Intake Coordinator	/ /
❑	❑	❑	Interpreters for the Deaf	/ /
❑	❑	❑	Nurse – Registered (RN)	/ /
❑	❑	❑	Nurse- Licensed Nurse Practitioner (LNP)	/ /
❑	❑	❑	Nurse- Licensed Practical (LPN)	/ /
❑	❑	❑	Occupational Therapist	/ /
❑	❑	❑	Ophthalmologist	/ /
❑	❑	❑	Optometrist	/ /
❑	❑	❑	Parent Educator	/ /
❑	❑	❑	Physical Therapist	/ /
❑	❑	❑	Physician	/ /
❑	❑	❑	Physician Assistant	/ /
❑	❑	❑	Psychologist - Licensed	/ /
❑	❑	❑	Service Coordinator	/ /
❑	❑	❑	Social Worker - Licensed Clinical	/ /

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❑	❑	❑	SLP - Clinical Fellow	/ /
❑	❑	❑	Speech Pathologist	/ /
❑	❑	❑	Translator: Non-Spanish Foreign Language	/ /
❑	❑	❑	Translator: Spanish Language	/ /
❑	❑	❑	Transportation Company	/ /
❑	❑	❑	Vision Teacher	/ /

A signature by the District below certifies provider specialties have been credentialed by the District.

District Signature _____ Date _____

District Contact Name (please print)_____ Phone # ( )_____

Please complete this Specialty Certification Form and submit to your District

Central Finance Office
Phone: 855-708-6612