Application Checklist
(For Actual Provider Performing Work)

Complete and return this form as part of your application packet.

(Applicant=Actual Provider Performing Work)

APPLICANT	DDDS USE ONLY
Provider Group/Clinic Working For: (please print)	**Evaluator Name:** (please print)
Provider Performing Work: (please print)	
Area of Expertise ☐ Developmental/Speech-Language ☐ General Medical ☐ Otolaryngology/Audiology/Vision ☐ Psychiatry/Psychology	Area of Expertise ☐ Developmental/Speech-Language ☐ General Medical ☐ Otolaryngology/Audiology/Vision ☐ Psychiatry/Psychology
☐ Acknowledgement of Professional Qualifications	☐ Acknowledgement of Professional Qualifications
☐ Statement of Agreement	☐ Statement of Agreement
☐ Curriculum Vitae or Resume	☐ Curriculum Vitae or Resume
☐ Copy of Government Photo Identification *(send separately from application packet)*	☐ Copy of Government Photo Identification