

### Public Contact Information *(\* Red starred information is required and will be posted online.)*

Date of Application:	
<b>Applicant's Name &amp; Credentials*</b> (CCC-SLP, M.A.T., M.S., SLP, M.A., Ph.D., Assoc. or Fellow/AOGPE, CALT, CALP, etc.):	
Business Name (if applicable):	
Number of Employees:	
Office/Business Street Address:	
City*/State/ZIP:	
Phone*:	- -
Alt. Phone:	- -
Email Address*:	
Website (if applicable):	

### Application Information *(All information is required. Qualifying certifications will be posted in your entry.)*

- List all Professional Organizations/Associations from which you have a license or certification (i.e. ALTA: CALP or CALT, AOGPE, IDA/CERI: SLDI or SLDS, AET, NILD, etc.)

Certifying Entity	Date of Certification	Level of Certification	# Hours in Training <i>(If Applicable)</i>	# Supervised Clinical Practicum Hours Completed <i>(If Applicable)</i>

*\* Please include copies of all licenses and certifications with your application. Please do not include certificates of completion or attendance as proof of certification. Certification must include a supervised clinical practicum to qualify.*

- Number of months/years **providing 1-on-1 tutoring** with students using MSL or Structured Literacy™ approaches/programs, beyond those involved in practicum or clinical hours:
- Services Offered:
 

<input type="checkbox"/> Educational Diagnostician <i>(Email us at <a href="mailto:ida_rmb@yahoo.com">ida_rmb@yahoo.com</a> for required additional submissions)</i> <input type="checkbox"/> Speech/Oral Language Intervention <input type="checkbox"/> Reading Intervention <input type="checkbox"/> Written Language Intervention <input type="checkbox"/> Math Intervention	<input type="checkbox"/> Organization/Study Skills <input type="checkbox"/> Counseling/Therapy <input type="checkbox"/> SAT/ACT/GED Preparation <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Other: <i>(listed at the discretion of the committee)</i>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
- Population(s) Served:
 

<input type="checkbox"/> Pre-K	<input type="checkbox"/> Grades K-5	<input type="checkbox"/> Grades 6-8	<input type="checkbox"/> Grades 9-12	<input type="checkbox"/> Adults
<input type="checkbox"/> Multilingual <i>(Specify language):</i>				
- Days/Hours Available:
- Locations offered:
 

<input type="checkbox"/> Office/Clinic	<input type="checkbox"/> Home Office	<input type="checkbox"/> Student Home	<input type="checkbox"/> Public Building	<input type="checkbox"/> Online/Video Teach
----------------------------------------	--------------------------------------	---------------------------------------	------------------------------------------	---------------------------------------------
- Current Rates *(we understand these are subject to change):*

8. What program/approach is the “foundation” or basis of your practice? Please be specific.
9. List any other approaches, methods and/or materials you incorporate into your teaching:
10. To what professional organizations do you belong and for how long have you been a member?  
*Please include copies of membership IDs or confirmation emails to verify memberships.*

11. Over the past four years, what education-related classes, conferences, workshops, trainings, etc. have you participated in?

Name of Class, Training, Workshop, Conference	Date(s) Attended	# Contact Hours	Organization/Host(s) /Presenter(s) Name(s)	Certificate of Completion or Attendance? <i>Please attach if available.</i>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>

**ADDITIONAL ITEMS TO SUBMIT**

- Your Resume** (You must include Higher Education Background citing schools, dates and degrees, and Education-Related Work History.)
- Copies of **Professional Certifications, Licenses, Endorsements**, etc. (see #1)
- Copies of **Membership** IDs for professional organizations (see #10)
- Copies of **Certificates of Completion or Attendance** (see #11)
- Any other professional training, experience, or relevant information not already in the application, that you would like to share with us.
- Letters of recommendation** (*for our internal use only*): Please provide **two recent** letters of recommendation from people who know you in a professional tutoring/therapy capacity.

**PROFESSIONAL or CORPORATE IDA MEMBERSHIP REQUIRED**

Are you a current IDA member\*\*?

Yes  IDA member number: \_\_\_\_\_ IDA Member Expiration: \_\_\_\_\_

**\*\*If you are a new member, please submit the confirmation email that you received when you joined.**

**\*Membership at the Professional or Corporate level is *required* for all providers. Non-members will not be considered for inclusion on the referral list. Not yet a member? Click here to join: [IDA - Professional Membership Benefits](#) or [IDA - Corporate Membership Benefits](#)**

---

**PLEASE READ THE FOLLOWING STATEMENT/TERMS CAREFULLY BEFORE SIGNING:**

- By my signature below, I certify and attest that all statements and representations I have made in this form are true, and I have all credentials, education, degrees, current licenses and/or certifications indicated.
- I realize that I must maintain current IDA membership at the appropriate level (professional, educational institution, corporate) to maintain a provider directory listing.
- I understand that inclusion in the provider directory does not denote that I am sanctioned or endorsed by the IDA or IDA-RMB. A listing is accepted and kept at the sole and complete discretion of the IDA-RMB.
- Additionally, I certify and attest that I have not been convicted of any felony or crimes involving professional malfeasance or abuse of any kind.
- I acknowledge that a disclaimer will accompany any information disseminated by *The International Dyslexia Association - Rocky Mountain Branch* (IDA-RMB), which indicates that all service providers listed in the database have signed this verification statement.
- By submitting this application, I agree to accept IDA-RMB's determination regarding this request to be listed.

Check here to agree with these terms. By typing or signing your name you also acknowledge that everything in this application is accurate to the best of your knowledge.

---

*Signature (please sign by hand if submitting by mail, or if scanning and emailing)*

Date:

## **Options for Returning your Completed Application and Supporting Documents:**

---

1. Download & complete the form on a computer. Save the file & email it to us with your other documents.
2. Download, print on paper & complete the form by hand. Scan and email it to us with your other docs.
3. If you prefer not to email us, you may also send your completed form and other docs via postal mail.

**Contact us by email: [ida\\_rmb@yahoo.com](mailto:ida_rmb@yahoo.com)**

**or by post: IDA-RMB Referral Committee**

**740 Yale Road  
Boulder, CO 80305**