

INSTRUCTIONS FOR SUBMISSION OF AUDIT DOCUMENTATION

1. Provide completed forms as necessary to document that at the time of application you met the discipline and professional practice experience requirements as identified in the *2009 Certification Handbook for Diabetes Educators*.
2. Submit the materials for receipt by the audit deadline date using certified mail or a traceable courier service to: NCBDE, Attn: Audit Process, 330 East Algonquin Road, Suite 4, Arlington Heights, IL 60005. (Telephone: 847-228-9795). **Note:** A certified mail, certificate of mailing or other courier receipt will serve as proof that the materials were submitted in the event the materials are not received by the deadline.

An audit submitted without all required information or incorrectly completed will be rejected. Any applicant who does not or cannot provide required information, or who does not meet eligibility requirements based on the documentation submitted, will be declared ineligible. Eligibility requirements are not waived nor are exceptions made.

CHECKLIST – AUDIT MATERIALS FOR INITIAL CERTIFICATION

Use this checklist to ensure that you have completed all required procedures before submitting your audit documentation.

- Have you completed all required forms?
- Have you included a copy of your current license or verification letter of licensure, registration or, if applying under a qualifying advanced degree, NOT license/registration, an official transcript was submitted with the original paper application.
- Have you made copies of all audit materials for your files?
- Have you arranged to send all audit materials to NCBDE by certified mail or traceable courier service?

Retain this checklist, a copy of your application/audit materials, and the proof of mailing for your records. Under no circumstances are materials, including copies, returned to applicants.

Acknowledgement of receipt of your audit materials should be sent by NCBDE no later than 2 weeks after receipt of materials.

SECTION A – Applicant Information and Discipline Requirement Verification Form

Complete both sections 1) and 2) as noted.

1) APPLICANT INFORMATION

Full Name as reported on the application _____
(print/type)

For identification purposes, provide the last 4 digits of your social security number or full date of birth (mm/dd/yyyy) as reported on your application: _____

Applicant's Signature _____ Date _____

2) DISCIPLINE VERIFICATION INFORMATION

Check **ONE** only and include the original date of licensure/registration as required.

I applied under the license/registration requirement: Enclosed is either a photocopy of current license, registration or certificate from the issuing credentialing body or an official written verification form from the appropriate credentialing body. Proof of license or registration that will be current at the time of the last day of the Examination window applied for (June 30 for spring examination; December 31 for fall examination) must be submitted to NCBDE no later than two weeks prior to the first day of the Examination window.

Identify the original date of licensure/registration*:

_____/_____/_____
Month Day Year

*See below:

- a. For clinical exercise physiologists, clinical psychologists, registered nurses, nurse practitioners, clinical nurse specialists, occupational therapists, optometrists, pharmacists (RPh or PharmD), physical therapists, physicians, or podiatrists, indicate the month/day/year you first received your license/certificate to practice in your professional discipline, i.e., the date your license/certificate was originally conferred.
- b. For physician assistants or dietitians, indicate the month/day/year you were first registered, e.g., for a registered dietitian, do not submit state license information; indicate the day you originally received registration with the Commission on Dietetic Registration. Do NOT submit state license information. Registered dietitians should not submit copies of state licenses.

I applied with a qualifying advanced degree. An official transcript was submitted with my original application and included information on the degree awarded, the date it was awarded, and the area of concentration.

SECTION B – Professional Practice Experience

Complete one Section B for each position being used to document meeting professional practice experience requirements.

Applicant's Name: _____ **Job # _____
 **(list jobs chronologically with #1 present job)

Job Title: _____

Department: _____

Institution/Practice Site: _____

Street Address _____

City, state and zip code _____

1. **Employment status** (circle one ONLY): Yes No I am currently employed/self-employed in this position.

2. **Dates of experience as a diabetes educator in this position:**

FROM _____ (mm/dd/yyyy) TO _____ (mm/dd/yyyy or "present")

3. _____ I provide(d) a minimum of 4 hours per week of diabetes self-management education ("DSME") in this position.
 initials

4. I am claiming a **total of** _____ **hours** in DSME for the dates of experience listed above.

5. **Practice setting** (check one only):

- Hospital Inpatient Only
- Hospital Outpatient Only
- Hospital Inpatient & Outpatient
- Other (specify) _____
- Physician's Office
- Community Health Agency
- Home Health Agency
- Self-Employment/Private Practice

6. **Provide a description of the setting.** Use a separate sheet of paper if necessary, and include your name and the last four digits of your social security number.

7. **Delivery method for DSME you provide(d) in this job** (check one only):

- Face to face only
- Electronic only (e.g., telephone, internet)
- Face to face and electronic

8. **For self-employment positions only, include referral information below:**

Applicants who are claiming self-employment experience must report sources of patient/client referrals, including names, addresses and telephone numbers, the length of time each has been a referral source, and number of patients/clients referred. Use a separate sheet if necessary. Health care professionals who may not have referral sources (e.g., physicians) must describe the process by which persons with diabetes come to their practices. **Complete information must be provided for each referral source.**

<u>Name of Referral Source</u>	<u>Address and Telephone</u>	<u>Length of Time as Referral Source</u>	<u>Number of Patients/ Clients Referred</u>
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I do not have referral sources for my private practice. Provide a separate sheet of paper describing the process by which persons with diabetes come to your practice (include your name and the last four digits of your social security number).

SECTION C – Practice Verification Form

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Provide one Section C for each Section B submitted. For employment positions, the immediate supervisor must complete box 1. For self-employment positions, a department head, chief of staff, Certified Diabetes Educator or other licensed health care professional who knows you and is familiar with your practice must complete box 2.

Applicant's Name: _____ Job # _____

Box 1 - For Employment Verification This statement must be signed and dated.

This applicant:

- 1) provides/d DSME as defined in the *2009 Certification Handbook for Diabetes* in an employment capacity a minimum of 4 hours per week or its equivalent;
- 2) has provided correct information regarding dates of experience and hours of DSME being claimed on Section B for this job; and
- 3) if DSME is/was provided solely by electronic means, there is a provision for client referral to another health care professional when face-to-face education is/was indicated.

I have reviewed Section B for this position and attest that I am the applicant's supervisor and that to the best of my knowledge all information is accurate, complete and truthful. I understand I may be contacted regarding this information.

Supervisor's Name (printed) _____
(must be applicant's immediate supervisor or notation regarding reason qualified individual other than immediate supervisor completing form must be included with this document)

Signature _____ **Date Signed** _____

(Original Signature Only)

Title _____ **Department** _____

Institution _____

Street Address _____

City _____ **State** _____ **Zip Code** _____ **Daytime Telephone** _____

(include area code)

E-mail Address _____

Box 2 – For Self-Employment Verification. This statement must be signed and dated.

- 1) I have known the applicant above since _____ (mm/yyyy) in my capacity as _____ (your professional title).
- 2) I am familiar with her/his practice as a diabetes educator.
- 3) I (circle one) → YES NO refer/referred individuals with diabetes to this practice.
- 4) The applicant a) provides/d DSME as defined in the *2009 Certification Handbook for Diabetes Educators* a minimum of 4 hours per week or its equivalent; and b) if DSME is/was provided solely by electronic means, there is a provision for client referral to another health care professional when face-to-face education is/was indicated.
- 5) I am NOT the applicant, spouse, business partner or employee of the applicant.
- 6) I have reviewed Section B for this position and attest that to the best of my knowledge all information is accurate, complete and truthful. I understand I may be contacted regarding this information.

Name (printed) _____ **Relationship to Applicant** _____

Signature _____ **Date Signed** _____

(Original Signature Only)

Title _____ **Department** _____

Institution _____

Street Address _____

City _____ **State** _____ **Zip Code** _____ **Daytime Telephone** _____

(include area code)

E-mail Address _____