

Employment Verification Certified Brain Injury Specialist Applicant

Information must be typewritten or neatly printed.

This section is to be completed by your immediate supervisor. If you are self-employed, a professional colleague must complete it. **This form must be submitted only when 12 months of full-time or 24 months of part-time work in approved brain injury experience are accrued.**

Applicant's name: _____

Applicant's position: _____

I hereby verify that this applicant has been employed for at least the past 12 months full-time or 24 months part-time and consecutively and has had direct contact with one or more individuals with a brain injury, 10 to 20 hours per week (25% of a 40-hour work week).

Print your name: _____

Your title: _____

Organization: _____

Address: _____

Phone: _____ Email: _____

Type of Brain Injury Service Provided: _____

Applicant's dates of employment: _____ to _____

Describe duties of the applicant: _____

Additional comments: _____

I hereby verify that the information provided above is true and accurate to the best of my personal knowledge.

Signature: _____ Date: _____