Tristate Trauma Network
Building hope through system transformation

TRAUMA RESPONSIVE CARE CERTIFICATION RENEWAL APPLICATION

Level of Current Certification: ____ Level 1 ____ Level 2 Expiration Date: _____

Name (as you would like it to appear on your certificate):

_____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Email address: _____

Your Certification belongs to you, please use personal contact information for renewal purposes.

Application for the credential must be accompanied by the following:

1. Completed application form
2. Evidence of 6 CEUs related to trauma completed since Initial certification date.
3. Application fee and individual membership renewal cost is $100. You will find the information and link to renew below.

In order to renew, you must also renew your Individual Professional Membership with the Tristate Trauma Network. Certification cannot be issued until you have a paid Individual Membership (payable on-line or by check). You can access membership via our website's members page: www.tristatetraumanetwork.org/members .

Send this application, requested documentation, and payment (if paying by check) to:
Tristate Trauma Network – P.O. Box 6331 Florence Kentucky 41042
You may also scan and send the application and supplemental documents to:
madamchik@tristatetraumanetwork.org

Applications will be reviewed within 2 weeks, and you will be notified if there are any missing pieces. Once approved, award letters and certificates will be mailed within one week of the review. Questions about the application process can be directed to Melissa Adamchik at madamchik@tristatetraumanetwork.org.

By submitting this application, I verify that the information is complete and, to the best of my knowledge, factual and true. I understand that failure to provide the required documentation may lead to delays in the processing of this application. I further understand that if any information is false or that I have misrepresented myself, I will be denied certification.

_____ _____
signature date

You have the option to have your name and contact information listed on our website's Member Access page under Trauma-Responsive Care Certified Professionals. Please let us know by filling out the blanks below what information you would like listed: (if you don't want info included, please leave blank; leave blank any fields you do not want included)

Name _____ Agency _____

Email _____ Phone _____