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):

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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. This completed application form
2. Evidence of 6 CEUs related to trauma completed since last certification date for one year renewal or 12 CEUs for two years renewal.
3. Payment: Renewal cost is $60 for one year renewals and $100 for two year renewals, which includes application fee and membership. This is payable online. You will find the information and link to renew below.

Renewal fee includes renewal of your Individual Professional Membership. Certification cannot be issued until you have completed this and paid (payable on-line or by check). You can access membership via our website's members page: www.tristatetraumanetwork.org/members . Click on the link to Membership Registration. Choose Individual Professional with TRCC Renewal as the type of membership. There is also a link to Membership on our new Certification page: www.tristatetraumanetwork.org/certification .

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: bmcclain@tristatetraumanetwork.org

Applications will be reviewed at the end of each month, 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 bmcclain@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____________________________________ Email ____________________________________

Agency __________________________________