Clinical/Associate Clinical Director Use: APPROVED:		*DATE:*
Director of Operations Use: APPROVED:		*DATE:*

Children's Dyslexia Centers, Inc.
MSLE Course Application Beyond Practitioner-1

Date: 4/01/2022	Policy #5 General Clinical	Owner: Clinical

Instructions: Please complete the following and attach copies of all required documents.

CENTER:	**ANTICIPATED START DATE:**	**OFFSITE PRACTICUM** ☐

Check the course you are applying to take:

☐ Practitioner-2	☐ Supervisor of Dyslexia Practitioner	☐ Therapist	☐ Instructor of Practitioner-1	☐ Instructor of Practitioner-2	☐ Instructor of Therapist

Name:

Home Address:

City:	State:	Zip:

Home Phone:	Cell Phone:	Business/Work:

Email:

Indicate the course(s) that you have completed and been certified:

Course	Course Instructor(s)	Completion Date	Tutoring hours	Levels Taught
MSLE Practitioner-1				
MSLE Practitioner-2				
MSLE Supervisor of Dyslexia Practitioner				
MSLE Therapist				
MSLE Instructor of Practitioner-1				
MSLE Instructor of Practitioner-2				
MSLE Instructor of Therapist				

Total Number Tutoring Hours (Include Practitioner-1 Course Practicum):

Total Number of Formal Observations (Include Practitioner-1 Course):

Continuing Education hours are current: ☐ YES ☐NO (not eligible for training courses)

Applicant's Certification and Statement

I certify that the information given herein is true and complete to the best of my knowledge.

I certify that all information given herein, including information regarding my current and prior employment listed above, as may be necessary to arrive at a course acceptance decision is true, accurate and complete. I understand that this Application is not, and is not intended to be, an application or a contract of employment and that any future employment is strictly "at will."

I hereby release any party giving information provided by me in this Application, as well as any party providing information about my background, from any and all claims and damages in connection with the investigation or verification of such information. In the event of future employment, I understand that false or misleading information given in this Application may result in my discharge.

I understand that parents/legal guardians of children currently enrolled at a Center may not participate in the training program until their children have completed the program.

It is the policy of the CDC to safeguard the privacy and security of the confidential information of its employees, children, and others. I understand that I may not discuss employees, children, trainees, or other staff. If I have any concerns, I will discuss those with the Center Director in private.

I understand I must demonstrate mastery of the content and practical application of skills throughout the training course. The Center Director's syllabus and course outline will provide details of the standards for mastery/success throughout the training course. If I do not demonstrate the expected level of mastery, I understand I will be discontinued from the program.

I understand the Children's Dyslexia Center's materials are proprietary. My use of the Children's Dyslexia Center's materials is restricted to my personal use with students. I will not copy or disseminate any of the materials for colleagues or for use in training others.

Signature: _____ Date _____

For Office Use:

- Center Director has verified the applicant is current with continuing education hours.
- Center Director will submit application, background clearances, and hiring/volunteer forms to corporate office for approval.

Signature: _____ _____

Center Director *Date*