CERTIFICATION REGARDING VOCATIONAL EVALUATION CREDENTIAL

The undersigned certifies that:

Option 1.) They possess a current certification/registration from the Professional Vocational Evaluators or Certified Vocational Evaluation Specialists Or;

Option 2.) They possess a current certification from the Commission on Rehabilitation Counselor Certification (CRCC). Or;

Option 3.) They possess a Wisconsin license for Professional Counseling. Or;

Option 4.) They possess a Bachelors or Master's degree in any of the following: Education, Psychology, Rehabilitation, Rehabilitation Psychology, School Psychology, Social Services, Special Education, or Vocational Evaluation. AND;

Meet the Standards for Educational and Psychological Testing as developed by the APA, AERA, and NCME to obtain, administer and interpret the required tests.

Additional for Option 4: Upon request the undersigned will produce a college transcript with successfully completed course work that demonstrates the following:

Test Construction, Evaluation, and Documentation
  Validity
  Reliability and Errors of Measurement
  Test Development and Revision
  Scales, Norms, and Score Comparability
  Test Administration, Scoring, and Reporting
  Supporting Documentation for Tests

Fairness in Testing
  Fairness in Testing and Test Use
  The Rights and Responsibilities of Test Takers
  Testing Individuals of Diverse Linguistic Backgrounds
  Testing Individuals with Disabilities

Testing Applications
  The Responsibilities of Test Users
  Psychological Testing and Assessment
  Educational Testing and Assessment
  Testing in Employment and Credentialing
  Testing in Program Evaluation and Public Policy

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Any person who is found to have administered tests without the required credential will be subject to cancellation of their service agreement with DVR. Upon request the undersigned will produce proof of current compliance with the credential option identified.

Option: _______

___________________________________________  ________________________________
Signature – Provider Authorized Representative   Date

___________________________________________  ________________________________
Printed Name and Title of Authorized Representative  Provider Agency Name