National Certification Council for Activity Professionals
National Center for Montessori and Aging
3015 Upton Drive Ste 103
Kensington, Maryland 20895 USA
T: 757-552-0653 E: info@nccap.org

Retirement Status Application

APPLICANT INFORMATION			
Last Name:	First Name:	Middle Name:	
Today's Date:	Last 4 of SSN:	Phone:	
Current Home Address:			Apt.
City:	State:	ZIP:	COUNTRY:
Personal Email:			

EMPLOYMENT STATUS			
Are you currently employed?	Yes	No	If yes, please list your occupation:

Name of Employer:		
Work Address:		
City:	State:	ZIP:

Type of Agency (SNF, AL, ADS, CCRC, Hospital, Home Care, Hospice, Rehab, Other – please specify):

What is your current level of NCCAP Certification? _____

AFFIRMATION

By submitting this application, I hereby request to be registered as "Retired" with NCCAP.

I understand that this indicates my intent to no longer maintain NCCAP requirements for professional certification.

If I choose to re-enter the field of activities, I understand I am required to apply for initial Certification and meet the current NCCAP Certification Standards.

I understand that no Continuing Education hours are required to maintain "Retired" status though I am required to pay the applicable renewal fee every two years.

When listing my NCCAP credential(s) after my name, I will use the designation "Ret." after the credential(s) to indicate my "Retired" status.

Please sign indicating everything you have stated in this application is true:

Your signature:_____Date: _____

National Certification Council for Activity Professionals
National Center for Montessori and Aging
3015 Upton Drive Ste 103
Kensington, Maryland 20895 USA
T: 757-552-0653 E: info@nccap.org

PAYMENT.

CHECK. Mail a check or money order made out to "NCCAP" to our office:
3015 Upton Drive, Ste 103, Kensington, MD 20895

CREDIT CARD. Pay online at NCCAP.ORG using our secure system or send us the following information:

Type of Card: Visa ___ MasterCard ___ AmEx ___ Discover _____

Last Name:_____ First Name: _____

Card Number: _____ Expiration Date: _____ CVV#_____

Credit Card billing address:_____ Apt: _____

City: _____ State: _____ Zip: _____ Country_____

Signature of Applicant:	Date:

While certification promotes and maintains quality, it does not license or confer a right or a privilege upon you or otherwise define the qualifications of any healthcare professional. Please allow 4-6 weeks for your initial application to be processed.