REGISTRATION FOR CERTIFICATION

PLEASE COMPLETE IN CAPITAL LETTERS & ATTACH A COPY OF VERIFICATION ID

Section One:

FIRST NAME: _____MIDDLE INITIAL(S) _____ LAST NAME: _____

DATE OF BIRTH: DD / MM / YYYY GENDER: _____

STREET ADDRESS: _____ PARISH: _____

TELEPHONE NUMBERS: (H) _____ (M) _____

E-MAIL ADDRESS: _____

HIGHEST EDUCATIONAL LEVEL ATTAINED: *(Tick the appropriate box* [√])

PRIMARY: ☐ SECONDARY: ☐ TERTIARY: ☐ OTHER: PLEASE SPECIFY ☐ _____

Section Two:

NAME OF TRAINING/ASSESSMENT CENTRE:

_____

PLEASE INDICATE ANY SPECIAL NEEDS RELATING TO ASSESSMENT [**e.g. Visual impairment, Physical disability**]:

_____

OCCUPATIONAL AREA: _____

LEVEL OF CERTIFICATION: _____

APPLICANT'S SIGNATURE: _____ **DATE**: _____

FOR OFFICIAL USE ONLY

Section Three:

CATEGORY OF TRAINING: EBT [ ] CBT [ ] IBT [ ] APL [ ]

OCCUPATIONAL STANDARD(S) AVAILABLE: YES [ ] NO [ ]

IF YES, CATEGORY OF OCCUPATIONAL STANDARD: NVQ [ ] CVQ [ ]

ASSESSOR(S) AVAILABLE: YES [ ] NO [ ]

ATC APPROVED FOR OCCUPATIONAL AREA: YES [ ] NO [ ]

FOR APL CANDIDATES SELF-ASSESSMENT RECOMMENDATION: _____

APPROVAL SIGNATURE: _____ DATE: _____

NB: ALL REGISTRATION FEES ARE NON-REFUNDABLE