

The Certified Work Capacity Evaluator

Forms Package Updated January 2007

Use this package for both original and re-certification applications

Print this package back-to-back

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The Certified Work Capacity Evaluator

Professional Certification Application

Name: _____ Degree: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____

Employer: _____

Department: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Education

Undergraduate Institution: _____ Years: _____

Field: _____ Degree: _____

Postgraduate Institution: _____ Years: _____

Field: _____ Degree: _____

Please photocopy most recent diploma and submit with application.

When and where did you attend the Functional Capacity Evaluation Certification Program?

Location: _____ Date: _____

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The Certified Work Capacity Evaluator

Professional Experience

List only your experience for the last five years. List most recent experience first.

Title: _____ From: _____ To: _____

Employer: _____ City: _____

Supervisor: _____ Title: _____

Duties: _____

Hours per week of work capacity evaluation work: _____

Title: _____ From: _____ To: _____

Employer: _____ City: _____

Supervisor: _____ Title: _____

Duties: _____

Hours per week of work capacity evaluation work: _____

Title: _____ From: _____ To: _____

Employer: _____ City: _____

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Duties: _____

Hours per week of work capacity evaluation work: _____

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The Certified Work Capacity Evaluator

Statement of Professional Practice

I hereby agree that the Work Capacity Evaluation services that I provide will be performed in a manner that is consistent with the highest standards of current practice. I certify that the evaluations that I conduct will be safe, reliable, valid, practical, and will provide utility. I further assert that I recognize the interdisciplinary nature of Work Capacity Evaluation and will participate with other team members in a supportive and cooperative manner. I understand that violation of any of these precepts will be sufficient cause for the revocation of my certification by Roy Matheson and Associates, Inc.

Signature: _____

Name: _____

Date: _____

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The Certified Work Capacity Evaluator

Professional Reference

Requested on Behalf of _____

Mail response directly to:

The Certified Work Capacity Evaluator Certification Committee
c/o Roy Matheson and Associates, Inc.
P.O. Box 492
Keene, NH 03431 USA

The Certification Committee has received an application for certification in Work Capacity Evaluation from the applicant named above. Your name has been submitted as a person who has utilized his or her services.

We would appreciate your providing the Certification Committee with the information requested and returning this form directly to the Certification Committee at the address listed above.

Note: Under the Information Practices Act, the information contained in this document may be released, upon request, to the individual to whom it pertains. This information, however, will not be released to the general public. We encourage each professional identified as a reference to be candid and forthright in his or her evaluation of the applicant.

Your Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Telephone Number: _____

Work Capacity Evaluation (Functional Capacity Evaluation) is an evaluation procedure used to gather information about an individual's physical ability to perform work tasks.

1. List the name(s) of the clinical or case management practice where you were employed when services were provided by the applicant:

2. Title you held when services were rendered: _____

3. How many of your clients/patients have received a Work Capacity from the applicant?

4. Were the fees charged for this service:
 Appropriate to the level of service Fair Excessive

5. Was the evaluator able to schedule your client/patient for evaluation in a timely manner?
 Very Prompt Fair Slow

6. Did the evaluation performed by the applicant meet your needs?
 Completely To a Large Degree Somewhat Not at All

7. Did the report submitted meet your needs?
 Completely To a Large Degree Somewhat Not at All

8. Was the report submitted in a timely manner?
 Very Prompt Fair Slow

9. Have you had occasion to criticize the work of the applicant?
 Yes No

If so, was the criticism accepted and acted upon?
 Yes No

10. Remarks: The Certification Committee will appreciate any amplifying information regarding negative responses to any of the above questions. Please include any other information that you consider to be relevant:

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Professional Reference

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Address: _____

City: _____

State: _____ Zip Code: _____

Telephone Number: _____

Work Capacity Evaluation (Functional Capacity Evaluation) is an evaluation procedure used to gather information about an individual's physical ability to perform work tasks.

1. List the place(s) where the applicant provided Work Capacity Evaluation (WCE) services which you utilized. Addresses are not necessary.

2. Title you held when services were rendered. _____

3. For how many of your clients/patients has the applicant provided WCE service(s)? _____

4. Were the fees charged for this service appropriate?
 Excellent Fair Excessive

5. Did the evaluation performed by the applicant meet your needs?
 Completely To a Large Degree Somewhat Not at All

6. Was the evaluator able to see your client/patient in a timely manner?
 Very Prompt Fair Slow

7. Did the report submitted meet your needs?
 Completely To a Large Degree Somewhat Not at All

8. Was the report submitted in a timely manner?
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Certified Work Capacity Evaluator Report Submission Form

Name: _____

Please list twenty (20) functional capacity evaluations that you have performed within the parameters of the Policies and Procedures.

Client's Last Name	Date of Evaluation	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____

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CWCE Application Pack Checklist

Name: _____

Please initial next to required forms indicating inclusion in the application pack. Items marked “*” should be included for re-certification.

<u>Required Forms</u>	<u>Initials</u>
Certification Application Form*	_____
Copy of Most Recent Degree and Transcripts	_____
Professional Experience Form*	_____
Statement of Professional Practice Form*	_____
List of 20 Reports for Evaluation	_____
\$200.00 US Dollar Payment*	_____

Please include this sheet as the coversheet to your CWCE application.

Reminder: Please remember that all three professional reference forms must be mailed directly to the office by the end of your critique process in order for your certification to be processed immediately.