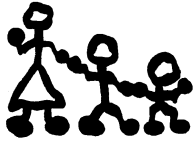


Incredible Years



APPLICATION FORM FOR CERTIFICATION AS A GROUP LEADER OF TEACHER CLASSROOM MANAGEMENT PROGRAM

NAME: _____

HOME ADDRESS: _____

_____ Zip: _____

HOME PHONE: _____

WORK: _____

Email: _____

OCCUPATION: _____

MONTH/YEAR OF CLASSROOM MANAGEMENT
OR DINA TRAINING: _____

TRAINER: _____

MONTH/YEAR OF PARENT GROUP TRAINING OR ACCREDITATION
AS PSYCHOLOGIST, SCHOOL COUNSELOR, OR TEACHER:

Please attach a 1-page letter describing:

- Your experience teaching preschool and early school age children
- Your experience with parents.
- Your goals, plans, philosophy of teaching.

**Please provide two letters of reference attesting to your teaching skills.
(preferable someone who is familiar with your work with the Incredible Years Programs)**

**This form must accompany your submission of videotape for review.
The Incredible Years 1411 8th Avenue West Seattle WA 98119**

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