

Mississippi Autism Board

P.O. Box 136
Jackson, MS 39205

Telephone (601) 359-6792 Fax (601) 576-2570 www.MSAutism.sos.ms.gov

APPLICATION FORM

PERSONAL INFORMATION:

Applying as:

_____ Behavior Analyst

_____ Assistant Behavior Analyst

Full Name (first, middle, last) _____

Previous names or aliases _____ SSN _____ Gender _____

Date of Birth ____/____/____ Are you a U.S. citizen? _____ Are you a legal resident of MS? _____ If no, State of

Residency _____ E-Mail Address _____

Employer Name & Address _____

_____ City _____ State _____ Zip _____ Business Telephone (____) _____

Home Address _____

City _____ State _____ Zip _____ Home Telephone (____) _____ Cell Phone (____)

EDUCATION AND TRAINING:

School _____

City _____ State _____ Zip _____

Type of Degree _____ Date of Completion _____

School _____

City _____ State _____ Zip _____

Type of Degree _____ Date of Completion _____

School _____

City _____ State _____ Zip _____

Type of Degree _____ Date of Completion _____

Current Certification by the Behavior Analyst Certification Board® and date of certification: _____

Do you hold any other licenses? _____ Type/Title: _____ In which jurisdiction(s)? _____

Are you requesting a Temporary license? ___No ___Yes

If you are requesting a temporary license, have you obtained all BACB requirements for certification? ___ Yes ___ No (If no, please provide further detail below, including, but not limited to expected date of receipt of certification results, etc.)

PERSONAL REFERENCES:

List three professional and one personal reference willing and able to attest to your character and aptitude for licensure.

| | | |
|---------------|----------------|----------------|
| _____ Name | _____ Phone | _____ Email |

QUESTIONNAIRE:

Please answer the following questions. Note: If you answer "Yes" to any of the questions below, please submit as part of your application a signed, dated type-written explanation providing specific details, including disposition of the matter.

1. Have you ever been charged with or convicted of a felony or misdemeanor other than a traffic violation? Yes___ No___
2. Have you ever had a complaint filed with a professional association or certifying, licensing, or registering body against you for alleged unethical behavior or unprofessional conduct? Yes___ No___
3. Have you ever had disciplinary action taken against you for unethical behavior, unprofessional conduct or any other grounds? Yes___ No___
4. Have you been diagnosed or treated for any physical emotional, or mental illness or disease, including drug or alcohol dependency, which limited your ability to practice behavioral sciences with reasonable skill and safety with the previous two (2) years? Yes___ No___
5. Has any state, jurisdiction, providence, or professional organization denied your application for credentials or professional membership? Yes___ No___
6. Has any governmental agency ever substantiated allegations made against you for physical, mental, or emotional abuse or neglect, sexual abuse, or exploitation against either a minor or an adult? Yes___ No___

AFFIDAVIT

NOTE: Any omissions, false or misleading information in, or in connection with this application, its attachments, or other communication(s) with the Mississippi Autism Board may be cause for denial or revocation of licensure on the grounds of lack of good moral character.

STATE OF: _____

COUNTY OF: _____

The undersigned, being sworn, duly states that he/she is the person who executed this application; that all statements herein are true in every respect; that he/she has not suppressed any information that might affect this application; that he/she will conform to the ethical standards of Mississippi Autism Board; and that he/she has read and understands this affidavit.

SIGNATURE OF APPLICANT: _____

DATE: _____

SWORN BEFORE ME THIS DAY _____ **OF** _____ **A.D. 20** _____

SIGNATURE OF NOTARY PUBLIC _____

PRINTED OR TYPED NAME: _____

MY COMMISSION EXPIRES: _____

SEAL

CRIMINAL BACKGROUND CHECK REQUEST FOR
FINGERPRINT CARD

I, _____, request that a fingerprint card be sent to me at the
{Please print full name}

address listed below for the purpose of licensure by the Mississippi Autism Board. ***I have enclosed the required \$35.00 processing fee (Check or money order).*** I understand that my licensure application file is not complete until the Mississippi Autism Board has received all licensure requirements and responses from both the Mississippi Criminal Information Center and the Federal Bureau of Investigations concerning my criminal history records check via fingerprint records.

Mailing Address: _____

Email address: _____

Business Phone#: _____

Cell Phone #: _____

Signature

Date