Eligibility Application for ENP Certification

ENP 9-1-1

Please fill in the following information as indicated.

○ NENA Member $420 ○ Non-Member $550 ○ Re-Certification $300 ○ Re-Examination $150

Type of payment included:

○ Check enclosed (made payable to: National Emergency Number Association (U.S. funds only))
○ Cashiers Check/Money Order ○ Organizational Check ○ Personal Check

○ Credit Card Payment: ○ Visa ○ MasterCard ○ American Express ○ Discover

Acct # Exp. Date

Signature

BACKGROUND INFORMATION

Name Agency/Company

Address

Phone Fax

Email

Type of NENA Membership: ○ Public Sector ○ Private Sector/Commercial ○ Telecommunicator ○ Non-Member

ELIGIBILITY REQUIREMENTS

In order to sit for the ENP Certification Exam, a candidate must meet the following experience criteria:

A. Three years experience in Emergency Communications.

OR

B. Three years experience with a commercial provider of Emergency Communications products and services.

SECTION 1.

Experience

Having satisfied the three-year minimum experience criterion, each additional year of experience (full-time equivalent) in Emergency Communications will count for two points, with a maximum of 10 points being granted.

Total Experience Pts ____

SECTION 2.

Education Attainment

Please indicate your level of education (choose highest degree):

High School Degree	0 Pts
Associate Degree	2 Pts
Bachelor Degree	4 Pts
Graduate Degree	6 Pts

Total Education Attainment Pts ____

SECTION 3.

Professional Development/Service

Please indicate the number and title of NENA in-person courses completed. Each full-day course will earn 1 point. A maximum of 4 points will be granted.

Course Pts

Course Pts

Course Pts

Course Pts

Course Pts

Please indicate if you have completed the NENA Center Manager Certification Program (CMCP). Worth 5 points.

Date/Location Pts

Indicate the state or national NENA office(s) you have held. One (1) point will be granted for holding a chapter or national NENA office, with a maximum of 1 point being granted.

Title of Office State Pts

The names of other professional certifications (e.g. CEM) that you hold. A certification will earn 1 point with a maximum of 1 point.

Name of Professional Certification Pts

Total Professional Development/Service Pts 0

TOTAL ELIGIBILITY POINTS (10 Points Required)

Section 1. (Maximum of 10) ____
Section 2. (Maximum of 6) ____
Section 3. (Maximum of 6) 0

GRAND TOTAL 0

Select Desired Test Period

○ Fall 2020 (October 3-17)
○ Winter 2021 (Jan 23-Feb 6)
○ Spring 2021 (April 3-17)
○ Summer 2021 (July 10-24)

Application Deadline

September 4, 2020
December 11, 2020
March 5, 2021
June 11, 2021

Complete this application and the Testing Center Application for Emergency Number Professional Certification Examination and send all paperwork and payments to:

NENA,1700 Diagonal Road, Suite 500, Alexandria, VA 22314
Fax completed applications to 202.618.6370.
Email completed applications to enpcert@nena.org.

ENP 9-1-1

Testing Center Application for

Emergency Number Professional Certification Examination

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided. →

A B C D E F 1 2 3 4 5 6

Candidate Information

Please enter your Name exactly as it appears on your current Government-Issued Photo I.D.

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

First Name | Middle Initial

Last Name | Suffix (Jr., Sr. , etc.)

Home Address - Number and Street | Apartment Number

City | State/Province | Zip/Postal Code

Country

Daytime Phone - - | Evening Phone - -

E-mail Address

Which edition of the exam do you wish to take? ○ U.S. ○ Canadian

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. CURRENT POSITION/ROLE IN EMERGENCY COMMUNICATIONS MANAGEMENT:

- ○ Manager
- ○ Supervisor
- ○ Commercial provider of products and services
- ○ Sworn Personnel
- ○ Telecommunicator
- ○ Other

B. YEARS IN CURRENT POSITION/ROLE IN EMERGENCY COMMUNICATIONS MANAGEMENT:

- ○ Less than 3 years
- ○ 3 - 5 years
- ○ 6 - 8 years
- ○ 9 or more years

C. PREVIOUS POSITIONS/ROLES IN EMERGENCY COMMUNICATIONS MANAGEMENT:

- ○ Manager
- ○ Supervisor
- ○ Commercial provider of products and services
- ○ Sworn Personnel
- ○ Telecommunicator
- ○ Other

D. YEARS IN PREVIOUS POSITIONS/ROLES IN EMERGENCY COMMUNICATIONS MANAGEMENT:

- ○ Less than 3 years
- ○ 3 - 5 years
- ○ 6 - 8 years
- ○ 9 or more years

E. CURRENT EMPLOYER CATEGORY: (Darken only one response.)

- ○ 9-1-1 Board
- ○ 9-1-1 Agency
- ○ Police Department
- ○ Fire Department
- ○ EMS
- ○ Independent System Provider
- ○ Consultant Services
- ○ Equipment Vendor/Distributor
- ○ Equipment Manufacturer/Developer
- ○ Telecommunications Company
- ○ Other

F. JOB CLASSIFICATION: (Darken only one response.)

- ○ Director, Agency Head, Supervisor
- ○ Police/Fire/EMS Manager
- ○ Project Engineer/System Designer
- ○ Database Manager/DB Developer/Addressing
- ○ Emergency Responder, Service Provider
- ○ 9-1-1 Coordinator
- ○ 9-1-1 Product Manager
- ○ City/County Elected Official
- ○ Vendor Sales/Marketing
- ○ Telecommunicator
- ○ Other

(Continue on page 2)

NENA, PROFESSIONAL TESTING CORPORATION, 1350 BROADWAY, Suite 800, NEW YORK, NY 10018
WWW.PTCNY.COM (212) 356-0660

ENP 9-1-1

Testing Center Application for

Emergency Number Professional Certification Examination

Eligibility and Background Information

G. TOTAL YEARS OF EXPERIENCE IN ALL EMERGENCY COMMUNICATIONS:

- ○ Less than 3 years
- ○ 6 - 8 years
- ○ 3 - 5 years
- ○ 9 or more years

H. HAVE YOU EVER BEEN CERTIFIED (CURRENTLY OR LAPSED) AS AN EMERGENCY NUMBER PROFESSIONAL?

- ○ Never Certified
- ○ Currently certified; applying for recertification
- ○ Previously certified but certification lapsed; applying for recertification, month/year of expiration: _____/_____

I. ARE YOU CURRENTLY A MEMBER OF NENA?

- ○ No ○ Yes

If yes, indicate type of membership:

- ○ Public Sector ○ Private Sector ○ Telecommunicator

NOTE: Membership is not required.

J. HAVE YOU TAKEN THIS EXAMINATION BEFORE?

- ○ No ○ Yes

If yes, when and under what name?
Date: _____
Name: _____

K. HIGHEST ACADEMIC LEVEL:

- ○ Some High School
- ○ High School Graduate or Equivalent
- ○ Some College
- ○ Associate Degree
- ○ Bachelor's Degree
- ○ Master's Degree
- ○ Doctoral Degree
- ○ Other

L. DID YOU PARTICIPATE IN A STUDY GROUP?

- ○ No ○ Yes

M. DID YOU COMPLETE NENA'S CMCP CLASS?

- ○ No ○ Yes

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your certification.

Race:

- ○ African American
- ○ Asian
- ○ Hispanic
- ○ Native American
- ○ White
- ○ No Response

Age Range:

- ○ Under 25
- ○ 25 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 60 +

Gender:

- ○ Male
- ○ Female

Candidate Signature

I have read the Application Handbook and understand I am responsible for knowing its contents. I certify that the information given in this Application is in accordance with Handbook instructions and is accurate, correct, and complete.

CANDIDATE SIGNATURE: _____ DATE: _____

Office Use

1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9
0	0	0	0

19101

REQUEST FOR SPECIAL NEEDS ACCOMMODATIONS

This Form must be fully completed if you are an individual with a disability covered under the Americans with Disabilities Act (ADA) and would like to request special test accommodations. Under the ADA, an Individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, walking) or a major bodily function (such as the neurological, endocrine or digestive system). The information you provide and any documentation regarding your disability and special test accommodations will be held in strict confidence. ***This completed Request for Special Needs Accommodations Form MUST be submitted with your application and received at least 8 weeks prior to the start of your testing period. Forms received after your application has been submitted and less than 8 weeks prior to the start of your testing period may result in a delay in processing.***

Candidate Information - Part I

_____
Name of Examination

_____
Testing Period

_____
Name (Last, First, Middle Initial)

_____
Address

_____
City *State* *Zip Code*

_____
Daytime Telephone Number

_____
E-mail Address

Special Accommodations

I request special accommodations as follows: (Check all that apply)

_____ Reader

_____ Scribe

_____ Extended testing time _____
Specify Total hours requested

_____ Tested separately

_____ Other special accommodations (Please specify.)

_____

_____

_____

Have you received the same or similar accommodations in the past? (If No, please explain below)

YES _____ NO ____

_____

_____

Signed: _____ Date: _____
Candidate Signature

Continue to next page for Part II

REQUEST FOR SPECIAL NEEDS ACCOMMODATIONS

Part II - Qualified Healthcare Professional Attestation

This section must be completed by a qualified healthcare professional who is licensed and has expertise in the disability for which these accommodations are sought. The qualified professional must have evaluated the candidate and is familiar with the candidate's condition.

Professional Documentation

I have evaluated _____ on _____/_____/_____ in my capacity as a
Examination Candidate *Month Day Year*

_____ .
Professional Title

The candidate discussed with me the nature of the examination to be administrated. It is my opinion that, because of this candidate's disability described below, he/she should receive the special testing accommodations requested.

Description of Disability: _____

_____

_____

Diagnosis code(s): _____

Are you licensed to diagnose the disability described in this Form? YES _____ NO _____

Date of disability onset: _____

Major life activity impaired by disability condition: _____

Signed: _____ Title: _____

Qualified Professional's Name (Print Name): _____

Address: _____

_____

Telephone Number: _____ E-mail:_____

Date: _____ License #:_____

Type of license: _____

State in which licensed: _____