



*American Academy for the Certification  
of Brain Injury Specialists*

## **Employment Verification – CBIS**

Information must be typewritten or neatly printed

This section is to be completed by your immediate supervisor. If you are self-employed, a professional colleague must complete it. **This form must be submitted only when 12 months of full-time or 24 months of part-time work in approved brain injury experience is accrued.**

Applicant's name: \_\_\_\_\_

Applicant's Position: \_\_\_\_\_

**I hereby verify** that this applicant has been employed for at least the past 12 months full-time or 24 months part-time and consecutively and has had direct contact with one or more individuals with a brain injury, 10 to 20 hours per week (25% of a 40-hour work week).

Print your name: \_\_\_\_\_

Your title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Type of Brain Injury Service Provided: \_\_\_\_\_  
\_\_\_\_\_

Applicant's dates of employment: \_\_\_\_\_ to \_\_\_\_\_

Describe duties of the applicant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional comments: \_\_\_\_\_  
\_\_\_\_\_

I hereby verify that the information provided above is true and accurate to the best of my personal knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_