Certified Safe Patient Handling Professionals™

CSPHC Application

Application Instructions

1. Download and save this form to your computer.
2. Complete application in its entirety prior to submission. All fields highlighted in **red** must be completed.
3. **Email application and all supporting documentation to info@csphp.org:**
   subject line: **CSPHC APPLICATION PACKAGE

The Certified Safe Patient Handling Professionals™ has established nine core competencies, identified as skill sets beneficial for those leading and supporting SPHM programs. While a Clinician applicant is not expected to be proficient in all areas, the Certification and Renewal Committee will examine an applicant's portfolio for five skill sets that are directly related to the application of SPHM "at the bedside": team leadership; training deployment; clinical knowledge and experience; risk analysis and control; and unit-specific customization.

Applicants should ensure that their professional experience, letter of recommendation, professional development and work product reflect their expertise and strengths in these areas. Additionally, once certified, certificants are encouraged to continue to build the nine core competencies through future professional development/continuing education.

NINE CORE COMPETENCIES: SKILL SETS

- **Financial Acumen** – Demonstrated through budgeting, cost justification, and/or vendor negotiation.
- **Team Leadership** – Demonstrated multidisciplinary collaboration and leading a cross-functional team.
- **Policy and Procedure Deployment** – Demonstrated through development, modification, and implementation of SPHM policy and procedure.
- **Training Deployment** – Demonstrated by development and delivery of training programs.
- **Clinical Knowledge and Experience** – Demonstrated through clinical job duties.
- **Risk Analysis and Control** – Demonstrated through analyses and linking control measures to risk results.
- **Program Promotion** – Demonstrated by internally/externally promoting the benefits and/or results of the SPHM program.
- **Program Audit** – Demonstrated by a formal review and reporting of program performance.
- **Unit-Specific Customization** – Demonstrated by adapting procedures to unit and patient-specific needs.

CSPHC APPLICATION CHECKLIST

The following documents must be submitted with your application portfolio:

☐ Photo ID (i.e., Driver's License, State Issued)

☐ Current certification application—please check website

☐ ASPHP Membership application *(optional, but provides discounted certification fees and professional development)*

☐ Clinical licensure, experience and proof of education
- Copy of current clinical license **AND**
- Resume **AND**
- Copy of the degree attained

☐ Proof of SPHM-related work experience
- Resume or employer job description

☐ Letter(s) of recommendation
- All letters must be dated within one-year of the application date and include the author's signature, contact information (name, employer, title, telephone and email) and preferably be submitted on letterhead.

☐ Evidence of competence
- SPHM work product
- Independent **OR** collaborative

☐ Professional development hours with supporting documentation (e.g., certificate of attendance, verification letter)—please refer to the chart at the end of the application

NOTE:

✓ **Only completed applications with all required documentation in the forms identified above will be accepted for review.**

✓ **If an application is not completed according to instructions, it will be returned to the applicant for resubmission.**

✓ **All fees are non-refundable.**

The Certified Safe Patient Handling Professionals™ is an affiliate of ASPHP.

The Association of Safe Patient Handling Professionals™

1. APPLICANT INFORMATION

Name _____ Date _____

Home Address _____

Personal Email _____ Phone _____ ☐ Home ☐ Mobile

Current Employer & Address _____

_____

Job Title _____ Work Email _____

Optional:
Please provide the name and contact information of the individual within your organization that you would like notified when you achieve your certification:

Name & Email Address _____

_____

CERTIFICANT REGISTRY

Publication of Certification: We endorse the ability to network with other SPHM professionals within the field. Please indicate your preference to have your name and certification level listed on our Certificant Registry.

◯ I agree to the publication of my name and certification level

◯ I do not want my name publicized

***IMPORTANT:** We must always have up-to-date contact information on file. Please remember to notify us if you change your email address, mailing address or employer.

2. CLINICAL LICENSURE, EXPERIENCE and PROOF OF EDUCATION

Requirements:

1) **Licensed healthcare clinician AND**
2) **Minimum of 3 years clinical experience AND**
3) **Minimum of an Associate degree**

Current Clinical Licensure

License Type _____

Expiration Date _____

Documentation to Be Provided: ☐ Copy of current clinical licensure

Clinical Experience

Current Employer & Address _____

_____

Job Title _____ Total # of Years _____

Dates of Employment (MM/YY) _____ (MM/YY) _____

Documentation Provided *(select one):* Resume Employer Job Description

If necessary, additional clinical experience information may be entered in Section 7

Post-Secondary Education

Institution/City, State _____

Subject Area _____

Degree Obtained _____ Total # of Years Attended _____

Dates Attended (MM/YYYY) _____ (MM/YYYY) _____

Documentation to Be Provided: Copy of Diploma

3. SPHM-SPECIFIC WORK EXPERIENCE

Requirement: Two (2) years of SPHM-specific work experience where your duties include responsibilities associated with an organization's SPHM program—may be full or part-time. [1]

Total # of Years _____

Dates of Employment (MM/YYYY) _____ (MM/YYYY) _____

Detailed Description—must include

- Percent of time dedicated to SPHM
- SPHM activities and responsibilities

_____

_____

_____

_____

_____

_____

Documentation Provided *(select one):* Resume Employer Job Description Letter from Supervisor [1]

[1] This information may be included in a Supervisor's Letter of Recommendation.

If necessary, additional information may be entered in Section 7

LET US KNOW!

How did you hear about SPHM certification?˅ *(select all that apply)*

☐ Colleague ☐ Conference ☐ Social Media ☐ Website ☐ Google Search ☐ Other: _____

Does your employer cover the cost of your certification or provide reimbursement?˅ *(select one)*

☐ Yes ☐ No ☐ Unsure

˅All information gathered is used for statistical purposes.

4. LETTERS OF RECOMMENDATION

Requirement: Must submit a total of three (3) letters of recommendation.[1]

1) **One letter written by a CSPHP (Certified Safe Patient Handling Professional) or Senior Leader within your organization**
2) **Two letters written by a colleague, supervisor or client familiar with your work and involvement in SPHM**

[1] Letters must describe your SPHM activities and reflect your expertise and strengths with the nine core competencies. Letters lacking sufficient detail will be returned for resubmittal.

Letter # 1 – CSPHP or Senior Leader

Name of Writer, Credentials, Employer and Job Title _____

_____

This letter is from a… *(select one):* CSPHP Senior Leader

Length of Time has Known Applicant in SPHM Role _____ years _____ months

Letter # 2

Name of Writer, Credentials, Employer and Job Title _____

_____

Relationship to applicant *(select one):* Mentor Colleague Supervisor Client/Customer

Length of Time has Known Applicant in SPHM Role _____ years _____ months

Letter # 3

Name of Writer, Credentials, Employer and Job Title _____

_____

Relationship to applicant *(select one):* Mentor Colleague Supervisor Client/Customer

Length of Time has Known Applicant in SPHM Role _____ years _____ months

5. EVIDENCE OF COMPETENCE

Requirement: One (1) work product as evidence of competence in the area of SPHM. [1.2]

Please provide information describing the work product and any evidence of authorship. A copy of the work product MUST be submitted with your application.

Examples of work products include: publications, assessments, training materials, policy and procedures, SPHM reports, etc.

[1] Vendor documents are not acceptable.

[2] Work products may be composed entirely by you or collaboratively with others in your organization.

Title and Description of SPHM Work Product _____

_____

Work Product is… *(select one):* Independent Collaborative

File Name of Work Product Attached _____

6. PROFESSIONAL DEVELOPMENT

Requirement: Sixteen (16) SPHM-related professional development hours during the last two years.

Applicants are offered a variety of options to earn professional development hours (PDH). Please refer to CSPHC Professional Development Hours Table.

All verification documentation must adhere to the requirements stated in the Professional Development Activities Chart. Failure to follow these guidelines will result in your application being returned for resubmittal.

- ✓ All letters must be signed by the author.
- ✓ Agendas will not be accepted as sole verification of an activity.
- ✓ Work-related activities (excluding training, education and competency) will not be accepted.

Instructions by Column:

- **A.** This number can be found on the Professional Development Activities Chart (far left-hand column).
- **B.** Briefly describe your activity. List your activities in chronological order.
- **C.** Record the date(s) that you were involved in the activity.
- **D.** Indicate the number of professional development hours (PDH) for this activity.
- **E.** List the specific document you are sending in that verify completion of the activity. Refer to the Professional Development Activities Chart for what verification documentation is required.
- **F.** What is the name of the electronic PDF file you are sending to us?

(A) ID #	(B) ACTIVITY DESCRIPTION	(C) DATE (MM/YY)	(D) PDH VALUE	(E) TYPE OF VERIF. DOC	(F) NAME OF PDF FILE
		TOTAL:			

PAYMENT INFORMATION

To pay by check, please make check payable to ASPHP

**Notate the following in the memo line: Professional Certification

Mail to: *ASPHP Headquarters, 10431 Perry Highway, Suite 210J, Wexford, PA 15090*

To pay by credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number _____ Exp Date _____

Security Code _____ Name on Card _____

Card Billing Address _____

You must select the following for your application to be processed:

☐ **I AGREE that all fees are non-refundable.**

7. ADDITIONAL INFORMATION

Regarding Section _____

_____

Regarding Section _____

_____

8. ATTESTATION STATEMENT

By submitting this application, I certify that I have read all of the instructions and requirements as outlined by the Certification and Renewal Committee, and have completed this application in its entirety. I further acknowledge that all information contained herein, including all supporting documentation submitted with the application, is accurate to the best of my knowledge, and recognize that any misrepresentation of self is immediate grounds for denial (or revocation if certification is granted).

By typing your name below, you are providing your electronic signature, which is equivalent to a handwritten signature, to complete this Application Form.

_____ _____

Applicant's Signature Date