

Construction Site Safety Master (CSSM) Verification of Qualifications (Form 800)



First Name _____ Middle Initial _____ Last Name _____
 Title _____ Social Security Number _____ Type of Contractor _____
 Company Name _____ Company Phone _____ Company Fax _____
 Company Address (Street, City, State, Zip) _____

Are you currently certified as an: (check appropriate space, enter certification number if yes)

Associate Safety Professional: Yes No
 Certification No. _____

Certified Safety Professional: Yes No
 Certification No. _____

Participant successfully completed which program: Master Trainer OR Instructor Certification Training Program (ICTP)

Education: List applicable degree(s) or course work completed.

Degree/Course _____	Name of School _____	Year Completed _____
Degree/Course _____	Name of School _____	Year Completed _____
Degree/Course _____	Name of School _____	Year Completed _____

Training: List applicable NCCER *Curriculum* training completed.

Craft/Program Completed _____	Date _____
Craft/Program Completed _____	Date _____
Craft/Program Completed _____	Date _____

Work Experience: ATTACH SAFETY RESUME

Company Name _____ Job Title _____ Length of Service _____
 Attach/include your safety resume or safety work history.

Company Name _____ Job Title _____ Length of Service _____
 Attach/include your safety resume or safety work history.

I hereby confirm that all information provided on this application is true and accurate.

Construction Site Safety Master Candidate Signature _____ Name/Title/SGN or NCCER Card #/SS# (type or print) _____ Date _____

I hereby verify to the best of my knowledge that the information provided on this application is accurate and that named candidate is qualified for Construction Site Safety Master Certification under the criteria established by NCCER for the Construction Site Safety Program.

Master Trainer Signature _____ Name/Title/SGN or NCCER Card #/SS# (type or print) _____ Date _____

Sponsor Representative Signature _____ Name/Title/SGN or NCCER Card #/SS# (type or print) _____ Date _____

ATS Name _____

Submit to: registrar@nccer.org or fax to 386.518.6255.