National Council on Technical and Vocational Education and Training

Gordon Town Rd., P.O. Box 179, Kingston 6, Jamaica, W.I. Telephone: (876) 977-1700-5 Fax: (876) 977-1707, 977-1115

Application for Assessment Services Authorization

Name of Organization/Entity: _____

Address: _____

Contact Name: _____ Position: _____

Telephone: (_____)_____ Fax (_____)_____
Area Code Number **Area Code Number**

Email: _____

Type of Application [check (✓) one]

A. Select the intended assessment approach:

❑ **Mobile** ❑ **Non-Mobile**

B. **Purpose of Application:**

❑ Initial Authorization

❑ Addition of Assessment Offerings

❑ Renewal of Authorization

Please provide details of programmes to be assessed (additional programmes may be listed on a separate sheet)

NB. Attach signed Qualification Plan(s) with this application

Programme Name	Programme Code	Level

Is the organization/entity registered with [check (✓) selection]:

		Yes	No
a)	Ministry of Education?	❑	❑
b)	Registrar of Companies?	❑	❑
c)	Other (specify) _____		

Does the organization/entity operate any satellite location? Yes ❑ No ❑

If yes, list address, phone number and administrator of each location (attach a separate sheet if necessary)

Address of satellite (partner) location/s_____

_____

_____

Telephone (_____)_____ Fax (_____)_____
Area Code **Number** **Area Code** **Number**

Name and title of on-site administrator/s_____

Location classification [check (✓)]: **Branch** ❑ **Partner/Assessment site** ❑

Has this organization/entity had any of its programme(s) [check (✓) selection]:

		Yes	No
a)	Accredited/Centre Approved?	❑	❑
b)	Denied Accreditation/Centre Approval?	❑	❑
c)	Accreditation/Centre Approval withdrawn?	❑	❑

Declaration (by Head of Organization/Entity)

(i) My organization/entity will co-operate fully with the NCTVET.
Yes ❑ No ❑

(ii) I hereby certify that the information provided on this application and supporting document(s) is accurate.
Yes ❑ No ❑

(iii) I understand that once authorization has been granted, the organization is subject to review and, if Standards for assessment service are not maintained, that authorization may be withdrawn.
Yes ❑ No ❑

My organization/entity will be able to facilitate an audit on _____/_____/_____.
dd mm yyyy

_____ _____ _____
Name (block letters) Signature Date
Head of Organization/Entity

For Office Use Only		
Application received by:		
_____	_____	_____
Name (block letters)	Signature	Date