SECTION B – Verification of Professional Practice Experience

(Please make copies as needed to verify your practice hours.)

Certificant's Name: _____

Certificant CDCES® certificate number: _____

Definition of Professional Practice

For purposes of recertification, practice means providing a direct or indirect professional contribution to the care and self-management education of people with diabetes.

What is Included in this Definition

This definition is intended to be as inclusive as possible of positions currently held by CDCESs, including service development, service management, public health/community surveillance, volunteer activities, diabetes-related research, clinical roles in diabetes industry, case management, professional education, consultant roles to industry or other providers, or others.

What is NOT Included

Employment in the manufacture, direct sales, or distribution of diabetes-related products or services in pharmaceutical or other diabetes-related industries, or jobs or volunteer activities unrelated to diabetes will not meet the practice requirement.

The 1000 hours of professional practice experience requirement must have (for renewal):

- taken place in the United States or its territories
- completed between January 1, 2022 for CDCESs renewing for the first time* – or the day after the deadline date of your last renewal by continuing education window or September 16, 2021 if certificant renewed by examination
- the 1000 hours can be earned at any time within the accrual window. There is no requirement about how or when this must be accomplished, e.g., to complete 200 hours per year each of the five years, or to be practicing at the time of application.

Supervisor/Professional Colleague Verification

For employment/volunteer positions, a supervisor must complete the verification. For self-employment positions, a department head, chief of staff, Certified Diabetes Care and Education Specialist or other licensed healthcare professional who knows you and is familiar with your practice should complete the verification.

Please print or type only (except for signature) and provide all *required information.

I have reviewed the renewal practice requirement guidelines above and attest that to the best of my knowledge all information is accurate, complete and truthful. I understand I may be contacted regarding this information.

Supervisor/Colleague Name (printed)* _____

Signature* _____ Date Signed* _____
(Original Signature Only)

Title* _____ Department _____

Institution* _____

Daytime Telephone w/area code* (_____) _____

E-mail Address* _____

6/2026

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