



To Whom It May Concern:

The Board of Directors and Medical Advisory Committee of the National Lymphedema Network (NLN®) are pleased that you are interested in becoming an **NLN Affiliate Training Course** and appearing in the NLN Resource Guide (online/in print). Please note that appearing in the NLN Resource Guide constitutes neither an accreditation nor an endorsement by the NLN, its Board of Directors or Medical Advisory Committee.

### **Current Guidelines**

Although no government-recognized national standards for treatment of lymphedema or accreditation of lymphedema training programs currently exists in the United States, the NLN has adopted standards set by the Lymphology Association of North America (LANA) for their national certification exam.

Lymphedema training programs that offer a minimum 135-hour course in the U.S. or abroad, with 1/3 theoretical and 2/3 practical (per LANA guidelines), are invited to apply for consideration of Training Program Affiliate Membership status and inclusion in the Resource Guide.

NLN Affiliate Training Programs are *required* to provide *NLN Information Packets* to all enrolled students upon course completion, and to provide brief information about the organization and opportunities available to course graduates. *By applying for Affiliate Membership, a training program agrees to follow these guidelines, and to support and promote the NLN, if accepted.* Affiliate Membership is not simply advertising, but a working relationship between the organization and the affiliate training program.

### **Resource Guide Coding**

In the Resource Guide, a listing of all NLN Affiliate Training Programs appears with codes indicating what the program offers, as well as a letter code assigned to each school. These codes appear throughout the Resource Guide, indicating the training program completed by each therapist (both independents and Treatment Center staff). Codes for schools indicate basic important components, such as number of training hours, who is eligible to enroll, etc. Only training programs that apply for, submit materials, and are accepted as Affiliate Members will be included in the listing; those that are not will not be listed. Therapists trained by courses other than NLN Affiliate Training Programs will be indicated with an asterisk (\*).

Every day the NLN receives an average of 50-100 calls on the NLN 800 Infoline and direct dial lines from patients and health care professionals nationwide seeking information and/or referrals to treatment centers, therapists and training programs. Our goal is to offer dependable referrals to quality, consistent education provided by knowledgeable, well-trained instructors. *Please note that the NLN reserves the right to refuse any application.*

Thank you for your interest in becoming an NLN Affiliate Training Program. We look forward to hearing from you.

Sincerely,

A handwritten signature in black ink that reads "Saskia Thiadens" with a long horizontal flourish extending to the right.

Saskia R.J. Thiadens, R.N.  
Founder/Executive Director  
enc



# NLN AFFILIATE LYMPHEDEMA Training Program Application

<b>FOR OFFICE USE ONLY</b>	
Date Recv'd:	_____
Ck#	_____
θ Charged on:	
__VISA __M/C __Disc __Amex	
All licenses/certs recv'd:	Y N
Staff List recv'd:	Y N
Curriculum recv'd:	Y N
School LETTER CODE:	_____
School CODES:	_____
Approved by:	_____

1. Name of Training Facility/Program: \_\_\_\_\_

2. Name & Credentials of Director: \_\_\_\_\_

3. Facility Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Website: \_\_\_\_\_ Hotline: \_\_\_\_\_

4. Please give an **overview of the Director's education and experience in lymphedema**, including where s/he received training/certification. **REQUIRED: Attach a copy of each certificate/license received.**  
{ I am a certified instructor, certified by: \_\_\_\_\_

5. **Is the Director the only instructor?**  Yes  No If no, please list the names of each instructor and provide a brief overview of educational and professional backgrounds relating to lymphedema. Please use flip side of sheet if needed. **REQUIRED: Attach copy of all professional certificates/licenses for each instructor.**

Name: \_\_\_\_\_

{ Certified instructor, certified by: \_\_\_\_\_

Background:

Name: \_\_\_\_\_

{ Certified instructor, certified by: \_\_\_\_\_

Background:

6. How long has your course/training program been in existence? \_\_\_\_\_ years \_\_\_\_\_ months

7. Who is eligible to take your course? *Please check all that apply.*

Physicians  Physician Assistants  Nurses/LVN's  Physical Therapists  PT Assistants

Occupational Therapists  OT Assistants  Massage Therapists

Other \_\_\_\_\_ →

8. **Please check all that apply to your course:**

- Provides instruction in **full body** manual lymphatic drainage (including head & neck)  
Provides instruction in  **upper body**  **lower body** manual lymphatic drainage only
- Other: \_\_\_\_\_
- Provides detailed instruction in compression **bandaging** of **all limbs**  
Provides detailed instruction in  **upper body only**  **lower body only** compression bandaging
- Provides instruction fitting compression **garments** for **full body** (incl. chest [vests], head, abdomen, etc.)  
 extremities **only**, **both** upper and lower  **upper extremities only**  **lower extremities only**
- Provides instruction in use of compression **devices** (ex: CircAid)  
*Which ones?* \_\_\_\_\_
- Certification (including certificate) in garment **measuring/fitting**  
If so, which companies? (Juzo, Jobst, etc.) \_\_\_\_\_
- Provides instruction in use of **pumps**
- Provides instruction in **diet/nutrition** for lymphedema
- Provides instruction in **skin care**
- Provides instruction in **exercise** (including special exercises)
- Provides instruction in **self-care methods**
- Provides instruction in: Other \_\_\_\_\_

9. What *method* of **manual lymphatic drainage** do you teach (i.e. who certified you as an instructor)?  Vodder  Földi  Casley-Smith  Other (please indicate):

\_\_\_\_\_

10. Attach a copy of your **curriculum/course outline** (remains confidential, only for your file) and explain in detail each topic addressed (use flip side if needed). *Course curriculum consists of:*

- 11. How many **days** does your course run? \_\_\_\_\_ days
- 12. How many **hours** of instruction do students receive? \_\_\_\_\_ hours  
 50 minute hours  60 minute hours
- 13. Do students have the opportunity to work with actual patients?  Yes  No
- 14. Are reimbursement issues addressed?  Yes  No
- 15. Is there a final exam?  Yes  No
- 16. If yes, what type?  Written  Oral  Practical/hands-on  Other: \_\_\_\_\_
- 17. Are students required to pass this exam/these exams in order to receive a certificate of completion?  Yes  No
- 18. Is **re-certification** required?  Yes  No If yes, how often? \_\_\_\_\_

*If no, do you plan to implement a re-certification program?*  Yes  No *When?* \_\_\_\_\_

19. How long is the re-certification course? \_\_\_\_\_ days \_\_\_\_\_ hours.
20. Do you offer support to alumni after certification?  Yes  No  
What type of support? \_\_\_\_\_
21. NLN Affiliate Treatment Centers are *required* to hand out *NLN Information Packets* to all graduating students, and to briefly describe NLN services/opportunities, promoting affiliate membership or membership in the NLN.  
Are you willing to do this?  Yes  No  
(Please contact the NLN office at least two weeks prior to each class to request info packets – thank you)
22. What would you say is your training program’s **greatest strength** and how does the program prepare a student for clinical work?
23. Please use this space to elaborate on any of your answers, and/or to note additional information about your course for the Review Committee. (Please use other side if needed)

**APPLICATION CHECK-OFF LIST**

The following **must** accompany your application (incomplete applications will not be processed):

- \_\_\_\_ Enclosed is a list of **all** instructors and **all** professional licenses/certificates
- \_\_\_\_ Enclosed is a copy of our course curriculum and related materials (confidential)
- \_\_\_\_ Enclosed are promotional materials about our school/program
- \_\_\_\_ Enclosed is a check or charge information for \$550.00 (or pay online at <https://www.shop.lymphnet.org>)

Amex  Disc  M/C  Visa : Card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_  
Customer code: \_\_\_\_\_ Signature: \_\_\_\_\_

Your initials here: \_\_\_\_\_ I understand that all applications are subject to review and approval, and that submission of this application does not guarantee Affiliate Membership status.

**\*\*I warrant that the statements provided in this application are true, and if found to be otherwise, I understand and agree that my facility’s Affiliate Membership status will be terminated immediately without compensation.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name & position/title

**Thank you.**

Questions? Please call or email: (415) 908-3681 / [nln@lymphnet.org](mailto:nln@lymphnet.org)

Please return this completed form, along with payment and copies of licenses, certificates and other required documents, to the address below. We look forward to working with you.