***National Council of Certified Dementia Practitioners***

55 Main Street, Suite 102  
Sparta, NJ 07871 USA

973.729.6601 Direct 877.729.5191 Toll Free

[www.nccdp.org](http://www.nccdp.org)[nccdpcorporate@nccdp.org](mailto:nccdpcorporate@nccdp.org)

**Grandfather Option**

**Certified Dementia Practitioner CDP**

**Application**

This option is only open for health care professionals who have a dementia or Alzheimer’s disease certification and or dementia or Alzheimer’s disease trainer certification from another national governing body or university. This option does **not** require you to take the NCCDP Alzheimer’s Disease and Dementia Care 8 hour live seminar. We do not accept college certificate programs in lieu of certification. A certification is different than a certificate of completion. The certification document you received will have an expiration date and sometimes a certification number.

To qualify you must meet the following criteria:

* Certified in dementia or Alzheimer’s disease by another national organization or university. Or certified as an Alzheimer’s disease or dementia trainer by another national organization or university.
* Licensed or certified in a health care profession and or an educator for a learning institution.
* A graduate of a 4 year university or a nurse.
* 1 year of paid work experience in a health care related setting or a learning institution.

We recommend that you please mail your application via FEDEX or UPS signed receipt.

Please attach the following documents to the CDP application:

* Copy of the dementia or Alzheimer’s disease certification you received from a national organization or university. You do not need to be in good standing as long as the expired certification is not more than 4 years.
* Copy of your college transcripts or degree. Except for nurses, please provide off the state registry the information showing your license is in good standing.
* A copy of your license or certification such as ADC, LNHA, etc. Except for nurses, please provide off the state registry the information showing your license is in good standing.
* A letter on company letter head from your supervisor stating you are employed. Your work experience can include more than one company.
* Resume

**Fee:**

The fee is $160.00. You may pay using a check or credit card. There is a $35.00 returned check fee. Please allow four to six weeks to process your application from the date we receive the application. A certification will be mailed to you.

**Renewal:**

You will be required to renew online every two years and a reminder notice will be sent to you 60 days prior to your expiration date via email and postal service. There is a $35.00 late fee. The fee to renew is $135.00. To renew you will need 10 CE’s or 10 CEU’s in any health care related topic from any source every two years. We do not ask for proof of the 10 hours unless you are selected for audit. You are asked to hold onto the certificate of attendance in case you are selected for audit. NCCDP offers an online learning portal should you need contact hours or CEU’s hours and the online learning portal is approved by over 60 governing bodies.

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Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST 4 DIGITS of Drivers license or state issued identification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all your credentials: Example; ADC, RN, LPN LNHA, CSW, PT, etc.

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**Employment Information:**

Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ ZipCode: \_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Employment: Month and Year: \_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_

Work Email Address and Web Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of organization? Example Nursing Home, Assisted Living, Home Care, CNA Training School etc

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Immediate supervisor name, email address and phone number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By providing this information you are authorizing a representative from NCCDP to contact your supervisor and verify employment: Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your position? Example; Director of Nursing

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide additional information if, less than one year of employment with your current employer.

Name of Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education:**

Name of College: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree Awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year graduated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dementia / Alzheimer’s disease Certification:**

What is the name of the national organization or university you received your dementia or dementia trainer certification from?

We do **not** accept a certificate program in lieu of certification. If you have a certification, the certificate document would indicate an expiration date.

Name of Organization: Example; International Council of Certified Dementia Practitioners

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Organization Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Web address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certification awarded? Example; Certified Dementia Practitioner CDP

What credential were you awarded?

Credential Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

What do the credential initials stand for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Attach a copy of your license or certification.

**Permission:**

I hereby give permission for my name to be listed on the CDP registry.

Sign your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We do not list personal information or your address. We do not sell your information to any company.

**Code of Ethics**  
  
National Council of Certified Dementia Practitioners®  
Code of Ethics for Certified Dementia Practitioners® (CDP®)

1. The CDP provides services to the health care profession with respect and dignity to the Dementia Client.
2. The CDP recognizes and respects the Dementia Client individuality.
3. The CDP participates in ongoing education and stays current with regards to Dementia issues and the National Council of Certified Dementia Practitioners Body of Knowledge.
4. The CDP maintains competence in his chosen profession.
5. The CDP will report to the National Council of Certified Dementia Practitioners any acts

by a Certified Dementia Practitioner that is illegal or unethical.

1. The CDP assumes absolute responsibility for your own individual actions.
2. The CDP will stay current with certifications with the National Council of Certified Dementia Practitioners.
3. The CDP insures the privacy of the dementia client and applies all HIPPA Regulations.
4. The CDP works to implement innovative ideas to the health care setting that may help a dementia client.
5. The CDP works to insure that quality of life is provided for the Dementia Clients residing in your health care setting.
6. The CDP networks with other health care professionals, attends Dementia / Alzheimer’s Seminars, Conventions, Support Groups and Ethics Committees.
7. The CDP respects the Dementia Clients customs, religious beliefs, and philosophy.
8. The CDP is truthful and avoids providing false or misleading information.
9. The CDP will not use the National Council of Certified Dementia Practitioners on any brochure or advertising without the express permission of this organization and in no way benefit directly or indirectly at the expense of the National Council of Certified Dementia Practitioners.
10. The CDP understands that its certification with the National Council of Certified

Dementia Practitioners does not in any way confer upon the CDP any type of licensure as a health care provider.

Your Name: (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_

Your Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Ethics Statement must be signed and included with your application.**

**Payment information: PLEASE RETURN THE APPLICATION IN ITS ENTIRITY.**

If paying by credit card:

Credit card type: Please circle Visa, Master Card, AX, Discover

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address for receipt (required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_

Who is this payment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give permission to charge my card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check which applies to you.

Check: \_\_\_ $160.00 CDP Certification

Check: \_\_\_ $182.00 CDP Certification and a CDP Pin

If, paying by check: Please make payable to NCCDP

Mailing address:

55 Main Street, Suite 102

Sparta NJ 07871

Our phone number is 973.729.6601

We accept delivery Monday through Friday 9 am to 5 pm EST.

We do not accept money orders or money grams

Returned check fee is $35.00

We do not return any part of the application so please make a copy for your records.

NCCDP will mail your CDP certification using the U.S. postal service. Be sure to notify us of address, email or name changes.

**Dispute:**

The NCCDP reserves the right to deny certification if your application does not meet our criteria. You have the right to dispute our decision. Please write to the NCCDP explaining your opinion and why we should reconsider your application. Please send your letter to the address noted. Your application fee will be returned in the event you are denied certification.

**Congratulations on all your achievements.**

Now that you have applied for additional dementia credentials you might be interested in pursuing CADDCT Certified Alzheimer's Disease and Dementia Care Trainer certification. Please go to our web site and click on certification and trainer and download the CADDCT pre-registration form which will list price, dates, location and information.

**Please tell us how you heard about NCCDP :Please check all that apply.**

Received a NCCDP Fax about an upcoming seminar  
  
Received a FAX OR BROCHURE from an approved NCCDP trainer about an upcoming   
 seminar   
  
Read about it in a newspaper, magazine, online social network or blog.

Pleaseindicate the name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Heard about it in class or association. Which association? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Searched the Internet

Received NCCDP newsletter

NCCDP LinkedIn. If LinkedIn which group?   
  
NCCDP Face Book

NCCDP Twitter

Friend / Co Worker

Board member: Which Association? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Association state, national conference or International Conference.  Which

Conference? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I heard about you because of NCCDP Alzheimer's disease and dementia Staff

Education Week press release.

Other? Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I don't remember