



**Certificate in Nonprofit Human Services Management Program**  
**2025 - 2026 Application**

**Supervisor's Recommendation Form**

To be completed by the applicant's supervisor.

*\*One recommendation form must be submitted for each individual applicant*

Applicant's Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Supervisor's Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

- I have supervised the applicant for \_\_\_\_\_ years and have known the applicant's work for \_\_\_\_\_ years.
- In five years, I expect the applicant could assume a position such as \_\_\_\_\_.

I recommend the applicant for participation in the Certificate in Nonprofit Human Service Management Program.

**Please also attach a signed recommendation letter (No more than 1 page)**

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Agency Commitment Form**

*To be completed by an authorized representative of sponsoring agency.*

<b>Tuition Fees:</b>	<b>Members</b>	<b>Non-Members</b>
• <i>Certificate in Nonprofit Human Services Management Program - Suffolk University</i>	\$3,650	\$7,000

**Please read the below information and sign to acknowledge:**

As the applicant's Sponsoring Agency representative, I have included a \$50 non-refundable Agency Application Fee (a one-time fee, regardless of the number of applicants) along with this application and I agree to pay the above tuition fee of \$\_\_\_\_\_.

"I understand that the \$50 application fee is non-refundable and the above tuition fee is not refundable after my employee attends the first class meeting. I understand that participants in the program must attend all classes to be eligible to graduate. My agency agrees to give enrolled employees paid time off in order to attend these classes and to adjust their work requirements accordingly for the duration of the program. I understand that all Certificate Program enrollees will commit themselves to continued employment with their sponsoring agency for at least one year following their graduation."

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative Name: \_\_\_\_\_ Title: \_\_\_\_\_

Return completed application, with application fee made out to the **Human Service Providers Charitable Foundation, Inc.**, by **June 1, 2025** to: *Certificate Program Admissions, Providers' Council, 100 Crossing Blvd. Suite 100, Framingham, MA 01702.*

Questions? Contact Nina Lamarre at [nlamarre@providers.org](mailto:nlamarre@providers.org) or 508.599.2256