

Clinical Certification Application

**I am completing the paper application to become credentialed by SASH
(check all that apply)**

- Certified Problematic Sexual Behavior Therapist (CPSBT)**
- Certified Sexual Wellness Therapist (CSWT)**
- Certified Sexual and Relational Trauma Therapist (CSRTT)**
- Certified Sex Offender Clinician (CSOC)**
- Distinguished Sex Therapist (DST)**

PROFESSIONAL STANDING

Applicants for certification with SASH must already be established professionals in a therapy related profession (i.e. Psychologist, Marriage and Family Therapist, Social Worker, Professional Counselor, Mental Health Counselor, Psychiatrist, Physician, Clinical Nurse Practitioner). Associate licensures are acceptable. Use this page and other documentation needed to support your professional standing.

CONTACT INFORMATION - Public

NOTE: This is public information used in our member directory and will be available to potential clients.

Name: _____
Practice Name: _____
Office Address: _____
City: _____ State: _____ Zip Code: _____
Office Phone: _____ Office fax: _____
Web site: _____
E-mail address: _____

CONTACT INFORMATION - Private

NOTE: This is contact information that will be kept in our office. Include whatever information you wish for us to have.

Home address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Other Phone: _____
Web site: _____
E-mail address: _____
Which address would you like for SASH to use in sending you correspondence from our offices? _____ Home _____ Office

DEMOGRAPHIC INFORMATION

Optional: for internal use only-Does not impact application decision

Gender: _____ Race: _____

LICENSURE - (if your state does not have a therapy licensure then please note this in the box below complete Appendix A). You must include a copy of your current license (s) with your application packet. You must also be licensed in the state in which you are currently practicing.

License (LPC, LMFT, etc..)	State	Year Given	Year Expires	Number

CERTIFICATION - List only therapy related certifications such as NCC (nationally certified counselor), CAS (certified addiction specialist), etc...

Certifying Body	Certification	Year Given	Year Expires	Number

PROFESSIONAL AFFILIATIONS

Group	Type of Membership
Does this organization have a code of ethics by which you abide?	___yes ___no
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Have you ever been disciplined or had a clinical license revoked by a State Licensing Board or equivalent (for international professionals)? ___yes ___no

Have you ever been sued professionally? ___ yes ___ no

Have you ever been convicted of a crime excluding minor traffic violations (e.g. speeding, parking violations etc.)

If the answer is yes to either question please explain on a separate sheet and include any documents relevant to these issues.

Supervision/Consultation Hours Received

Add additional pages for additional supervisors

Consultant/supervisor	Hours of consultation/supervision
Setting	Dates
Type of consultation/supervision	
Group _____ Individual Case Consult _____ audio _____ video _____ Live observation _____ co-therapy _____	

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References

You are required to submit two types of references: Professional and Supervisory/Consultation.

Use the provided forms to complete the supervisor verification/recommendation for your application.

To expedite receipt of the required reference/verification we suggest providing each individual with a stamped envelope addressed to

SASH
 Attention Credential Committee
 PO Box 916
 Acworth, GA 30101

Note: Individuals may not be remunerated for providing a letter of reference.

