

## Clinical Certification Application

**I am applying to become credentialed by SASH in the following:  
(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.**

<b>License</b> (LPC, LMFT, etc..)	<b>State</b>	<b>Year Given</b>	<b>Year Expires</b>	<b>Number</b>

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

<b>Certifying Body</b>	<b>Certification</b>	<b>Year Given</b>	<b>Year Expires</b>	<b>Number</b>

## **PROFESSIONAL AFFILIATIONS**

<b>Group</b>	<b>Type of Membership</b>
<b>Does this organization have a code of ethics by which you abide?</b>	<b>___yes ___no</b>
<b>Group</b>	<b>Type of Membership</b>
<b>Does this organization have a code of ethics by which you abide?</b>	<b>___yes ___no</b>
<b>Group</b>	<b>Type of Membership</b>
<b>Does this organization have a code of ethics by which you abide?</b>	<b>___yes ___no</b>

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 _____	

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

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

**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.**

## Signature Page

We require that all references be submitted and maintained as confidential references.

In signing this application form, I agree to waive any rights the law might allow in seeking to review or otherwise learn the contents of the professional reference(s) or consultant/supervisor reference(s) sent to the Society for the Advancement of Sexual Health (SASH) as a part of my certification application. I understand these reference letters will be available only to members of the Certification Committee and the SASH Board.

I verify that the information included with this application packet has been voluntarily supplied for the purpose of being certified for the above-selected certifications by SASH.

I verify that the information in this application is accurate to the best of my knowledge and authorize SASH to verify this information.

I understand that in the process of verifying the included information these facts might become known to third parties. I expressly waive any claim to confidentiality of the material enclosed in this application packet except where otherwise noted.

I understand this application packet will be reviewed by the Credential Committee of SASH and that my application will be evaluated based on the standards in place at the time I submit my application.

Every effort has been made to keep the application and review process objective, I understand that there is a subjective part of evaluating my application. I acknowledge that if my application is not accepted I can appeal to the SASH Board of Directors. The decision of the SASH Board is final. I agree that I am voluntarily submitting this application and that if my application is not accepted I will in no way seek to hold SASH or any of its officers, committee members, or members liable for such action.

I have paid the required application fee and understand it is non-refundable. A \$25.00 fee will be charged for any returned checks.

I understand that I must renew my application every two years and demonstrate completion of 30 hours of continuing education in accordance with the continuing education guidelines specified in each SASH credential.

Should any information included in this application change during the application process, I will notify SASH within 14 business days.

I affirm under the laws of the United States that the information I have supplied in this application and any copies of documents that I am sending to support my application are true and correct to the best of my knowledge.

*By typing your name and the date below (rather than signing), you understand, consent, and are authorized and agree that your electronic signature is the legal equivalent of your manual signature on this application and constitutes acceptance and agreement as if actually signed by you in writing.*

---

printed name    / \_\_\_\_ / \_\_\_\_    signature