# ACKNOWLEDGEMENT OF PROFESSIONAL QUALIFICATION AND CONFIDENTIALITY

APPLICANT'S NAME: _____
(Last) (First) (Middle)

OFFICE ADDRESS:_____ MAILING:_____
_____ _____
_____ _____

EMAIL:_____ PHONE NUMBER:_____

FAX NUMBER:_____ BIRTH DATE:_____

GENDER: MALE: ☐ FEMALE: ☐

GRADUATE EDUCATION:

MD: _____
(Name of College) (Year of Degree)

PhD: _____
(Name of College) (Year of Degree)

PsyD: _____
(Name of College) (Year of Degree)

EDD: _____
(Name of College) (Year of Degree)

POST GRADUATE SCHOOL TRAINING (Internship, residency, fellowship, etc.):

NAME OF INSTITUTION: _____

TYPE OF TRAINING: _____

YEAR OF TRAINING: _____

LICENSE NUMBER: _____ STATE: _____

EXPIRATION DATE: _____ TAX ID #: _____

NATIONAL BOARD: YES ☐ NO ☐ YEAR:_____

BOARD CERTIFIED: YES ☐ NO ☐ YEAR:_____ BOARD ELIGIBLE: YES ☐ NO ☐ YEAR:_____

NATIONAL REGISTER OF HEALTH SERVICE PROVIDERS ON PSYCHOLOGY: YES ☐ NO ☐ YEAR: _____

AREAS OF MEDICAL OR PSYCHOLOGICAL EXPERTISE:_____
_____
_____

SIGNATURE:_____ DATE:_____