

**ACKNOWLEDGEMENT OF PROFESSIONAL QUALIFICATIONS**

APPLICANT NAME: \_\_\_\_\_  
(Last) (First) (Middle)

OFFICE ADDRESS: \_\_\_\_\_ MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_ GENDER: MALE:  FEMALE:

GRADUATE EDUCATION:  
\_\_\_\_\_  
(Name of College) (Degree) (Year of Degree)

POST GRADUATE SCHOOL TRAINING (Internship, residency, fellowship, etc.):  
NAME OF INSTITUTION: \_\_\_\_\_  
TYPE OF TRAINING: \_\_\_\_\_  
YEAR OF TRAINING: \_\_\_\_\_

LICENSE INFORMATION:  
\_\_\_\_\_  
(License Number) (Expiration Date) (State of License)

AREAS OF MEDICAL OR PSYCHOLOGICAL EXPERTISE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_