EXHIBIT C1

ACKNOWLEDGEMENT OF PROFESSIONAL QUALIFICATIONS

APPLICANT NAME:____

(Last) (First) (Middle)

OFFICE ADDRESS:

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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:______________________________

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