

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: _____

