EXHIBIT C1

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:_____

_____

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