EXHIBIT C3

ACKNOWLEDGEMENT OF PROFSSIONAL QUALIFICATIONS

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

GENDER: ☐ MALE ☐ FEMALE ☐ PREFER NOT TO ANSWER BIRTH DATE: _____

SOCIAL SECURITY NUMBER: _____

GOV'T ID #: _____ STATE: _____ EXPIRATION DATE: _____
(driver's license, U.S. passport, U.S. military ID, etc.)

OFFICE ADDRESS: _____

MAILING ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

EMAIL: _____

GRADUATE EDUCATION:

_____
(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: _____

AREA(S) OF MEDICAL OR PSYCHOLOGICAL EXPERTISE: _____

_____

_____ _____
Applicant Signature Date