CBASP TRAINING & CERTIFICATION APPLICATION
Virginia Commonwealth University
Richmond, Virginia

Application for CBASP Training Program*

Name: ___________________________________ **Date:** _____________________
(please print)

Current Title/Position: ____

Work Address: ______________________ **Home Address:** ____________________

______________________ ____________________

______________________ ____________________

______________________ ____________________

______________________ ____________________

Phone: ______________________ **Phone:** ____________________

FAX: ______________________ **FAX:** ____________________

email: ______________________ **email:** ____________________

How would you like us to correspond with you? Regular mail _____ Phone _____

FAX _____ email _____

***Applicant must be 2 years post degree/residency**

***Educational Background*:**

Highest Degree: ______ Institution __________________________________

Field/Specialty: ________________ Year Graduated: ______________

***<u>Professional Credentials</u>*:**

Professional Licensure: Yes _____ No _____ State of Licensure: __________

Year Licensed in Present State: ______

Have you ever been sued? Yes _____ No _____

License ever been revoked? Yes _____ No _____

***<u>Type of Professional Work</u>*: (check those activities which apply)**

Conduct psychotherapy with clients/patients _____ Inpatients _____

Outpatients _____ Individual _____ Group _____ Adolescents _____

Children _____ Couples _____ Geriatric patients _____

Conduct psychotherapy research _____

Supervise psychotherapy practice with colleagues _____

Supervise psychotherapy with graduate students _____ Teach in a university _____

***Applicant must be 2 years post degree/residency**

Current theoretical orientation (please specify) ________________________________

____

Theoretical orientation of your academic training in psychotherapy (please specify)

____

Certified to administer other therapy models: Yes _____ No _____

Specify model(s) ____

____

Please furnish us your VITA and any other information which might help us evaluate your application:

____

____

____

____

(use addition pages if necessary)

I give permission to the CBASP National Training Center to contact 2 licensed professionals in my specialty area (see Reference Information below) AND geographical area to discuss my training application process. Please request that each professional send us a letter of recommendation as soon as possible.

____ _______________________

Signature of Applicant **Date**

***Applicant must be 2 years post degree/residency**

Reference #1

Name of Reference: ____

Degree/Position: _________/____

Address: ____

____

____

Phone: _________________________ FAX: _________________________________

email: ____________________________________

James P. McCullough, Jr., PhD, Director

CBASP National Training Center

Department of Psychology

Virginia Commonwealth University

808 W. Franklin Street

Richmond, VA 23284-2018

***Telephone*: 804-828-5641 *FAX*: 804-828-4004**
***email*: jmccull@vcu.edu**

***Applicant must be 2 years post degree/residency**

Reference #2

Name of Reference: ____

Degree/Position: ________/____

Address: ____

____

____

Phone: _______________________ FAX: _________________________________

email: ____________________________________

James P. McCullough, Jr., PhD

CBASP National Training Center

Department of Psychology

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