Board of Christian Professional and Pastoral Counselors

Certified Post-Traumatic Stress Disorder (PTSD) Specialist

Application

Thank you for your interest in pursuing the specialty designation as a ***Certified PTSD Specialist***. The designation of ***Certified PTSD Specialist*** is one of three specialties being offered through the BCPPC. To apply, you are required to first be credentialed with one of the four levels available through the BCPPC.

Please complete and **PRINT** all information that is requested in a legible manner, or mark N/A if not applicable. Illegible and/or incomplete applications will be returned to the applicant. The BCPPC will not disclose the confidential information given in this application without your express, written consent. ***Please allow 4-6 weeks for processing.***

I. Demographic Information

Last Name _____ First Name _____ MI _____

Home Address _____

City _____ State _____ Zip _____ Country _____

Name of Practice/Organization/University/Church, etc., where you work and/or provide counseling/caregiving services _____

Business Address _____

City _____ State _____ Zip _____ Country _____

Work Phone _____ E-Mail Address _____

Fax _____ Secondary/Emergency Phone _____

Cell Phone (***optional***) _____ Home Phone (***optional***) _____

II. Verification of Professional/Formal PTSD Education and Training

Applicants for certification must document their formal course work/training in PTSD studies and show the required **45** clock hours (15 of which to be Biblically integrated training) based on the specialty designation. Please include documentation that verifies your education and/or training (e.g., transcripts, certificates of completion, letters, etc.). Please use additional sheets if necessary.

Course/Presentation Title:	
Instructor:	**School/Organization:**
Type of Training:	**# of Clock Hours:**

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Instructor:	**School/Organization:**
Type of Training:	**# of Clock Hours:**

Course/Presentation Title:	
Instructor:	**School/Organization:**
Type of Training:	**# of Clock Hours:**

Total number of clock hours of professional/formal PTSD education and training submitted _______

III. Verification of PTSD Counseling

Applicants for certification must document that they have completed the required **75** hours of PTSD counseling with clients. All counseling must be provided on a ***face-to-face basis*** and can include a variety of modalities (e.g., individual, group, couple, family, etc.), as well as different client populations (e.g., adolescents, adults, children, etc.). Please use additional sheets if necessary.

Place Where Services Were Provided:	**Dates of Service:**
Position within the Organization:	**Total # of Contact Hours Providing PTSD Counseling:**
Type of Training/Experience Providing PTSD Counseling (specify the # of hours in each category): _______ **Indiv. Adult Males** _______ **Indiv. Adult Females** _______ **Couples** _______ **Group (Males)** _______ **Group (Females)** _______ **Minors** **Other (please specify):** ________________________________	

Place Where Services Were Provided:	**Dates of Service:**
Position within the Organization:	**Total # of Contact Hours Providing PTSD Counseling:**
Type of Training/Experience Providing PTSD Counseling (specify the # of hours in each category): _______ **Indiv. Adult Males** _______ **Indiv. Adult Females** _______ **Couples** _______ **Group (Males)** _______ **Group (Females)** _______ **Minors** **Other (please specify):** ________________________________	

Place Where Services Were Provided:	**Dates of Service:**
Position within the Organization:	**Total # of Contact Hours Providing PTSD Counseling:**
Type of Training/Experience Providing PTSD Counseling (specify the # of hours in each category): _______ **Indiv. Adult Males** _______ **Indiv. Adult Females** _______ **Couples** _______ **Group (Males)** _______ **Group (Females)** _______ **Minors** **Other (please specify):** ________________________________	

Place Where Services Were Provided:	Dates of Service:
Position within the Organization:	Total # of Contact Hours Providing PTSD Counseling:
Type of Training/Experience Providing PTSD Counseling (specify the # of hours in each category): _____ Indiv. Adult Males _____ Indiv. Adult Females _____ Couples _____ Group (Males) _____ Group (Females) _____ Minors Other (please specify): _____	

Total number of contact hours of PTSD counseling submitted _____

VIII. Attestation and Signature

I affirm and attest by my signature below that I have answered all the questions in this Application truthfully and with full disclosure and have attached all requested supporting documentation. I understand that the information included in this Application has been voluntarily supplied for the purpose of being certified as a PTSD Specialist through the Board of Professional and Pastoral Christian Counselors (BCPPC)

I authorize the BCPPC to verify this information and understand that in the process of verification, these facts might become known to third parties. I expressively waive any claim to confidentiality of the material enclosed in this Application except where otherwise noted.

While effort has been made to keep the application and review process objective, I understand that there is a subjective element to evaluating my Application. I acknowledge that if my Application is not accepted, I can appeal the decision to the BCPPC Credential Committee. I further agree that because I am voluntarily submitting this Application and if it is not approved, I will in no way hold the BCPPC, the AACC, or any of their officers, board members, or employees liable for any such action.

I have enclosed the required ONE TIME application fee of forty-nine dollars ($49.00), *made out to AACC*, and understand that it is non-refundable.

I understand that I will need to renew my credential on an annual basis (ever year) and verify the completion of required Continuing Education hours. This also entails maintaining an active BCPPC credential at the appropriate level.

Applicant Signature Date