

INDIVIDUAL PROVIDERS OF STBH CLINICAL SERVICES

Complete this form for each therapist providing STBH clinical services

Name:			
Phone Number:			
Email:			
LICENSURE/CERTIFICATES (List each license held in Virginia)			
Type of License:		Issuing Entity:	
Date of Issue:		Expiration Date:	
Type of License:		Issuing Entity:	
Date of Issue:		Expiration Date:	
Type of License:		Issuing Entity:	
Date of Issue:		Expiration Date:	

SPECIALTIES, CERTIFICATIONS & EXPERTISE

(Please attach a resume for each therapist highlighting trainings and certification)

Type of Specialty:

Languages:

(Please List)

**Please Indicate Certificates and/or training in the following:
(Please attach verification)**

- Cognitive Behavioral Therapy (at least 12 hours)
- Other Trauma Specific Treatment (at least 12 hours)
- Risk Assessment

Please list: _____

All of the information submitted in this application is accurate and truthful to the best of my knowledge.

Clinician's Signature/Title

Date

Printed Signature