SPIRIT 2 SPIRIT
Healing

Name: _____

Training Application

PLEASE FILL OUT APPLICATION IN ITS ENTIRETY AND
RETURN WITH ALL REQUIRED SUPPORTING DOCUMENTATION
TO: SPIRIT2SPIRIT ATTN: KAT CROSS

Fax # 575.613.7167

PLEASE DO NOT MAIL THIS PACKET TO FL, FAX or SCAN IT.

This Form Must Be Filled Out In Its Entirety and Turned In With All Required Supporting Documentation Prior To Beginning Any Module of the CTT® or CTP® Certification Programs.
If any of the questions are not applicable, please answer N/A for that question.

Training Application

Select one: ☐Certified Trauma Therapist (CTT®) ☐Certified Trauma Professional (CTP®)

Contact Information

Full Name: _____

Credentials: _____ **SSN:** _____ **DOB:** _____

Home Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Company Name: _____

Business Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Fax:** _____

Email Address: _____

Education: Current Level of Education:

◯ Bachelor's Degree ◯ Master's Degree ◯ MD ◯ PhD ◯ Other_____

Academic Institution	Date of Graduation	Degree Earned

Certifications (Professional & Job Related) Certifications Turned Into Spirit2Spirit for Certification Purposes Must Be Current:

Certifications Held	Date of Certification

Licenses: Licenses Turned Into Spirit2Spirit for Certification Purposes Must Be Current

License Held	State	License Number

Department Of Law Enforcement: (Police Academy, EMT/EMS, Firefighters Certificate, Etc)

Certification Held	Date of Completion

Supervision

If You Currently Receive Any Form Of Job Related Professional Supervision Please Fill Out Information Below

Supervisors Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____

Email:_____

Ethical Violations/Malpractice Claims

Have ANY Malpractice Claims Been Brought Against You? _____Yes _____No _____N/A

Have ANY Professional, Legal or Ethical Hearings Been Brought Against You? _____Yes _____No

If Yes Please Attach A Summary Of The Details Including Past and Pending Actions Against You As Well As Copies of All Relevant Information, Including Judgments, Pertaining To The Claims.

Required Documentation

The Following Documents Must Be Submitted In Order To Process Your Application

- Completed Application With Payment
- Copies of Diplomas/Certifications/Licenses
- Copies Of Current Resume/Curriculum Vitae
- Copy of Malpractice Insurance (CTT® Only)
- Letter of Recommendation From Immediate Supervisor (Non-Degree CTP® Only)

By Signing This Application, I hereby certify, that to the best of my knowledge and understanding, the information provided on this form is true and accurate.

_____ _____

Signature **Date**

_____

Print Name

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Personal Information

Dates of Program: _____ Location: _____

Full Name:_____ Date of Birth: _____ Age: _____

Female:_____Male:_____Trans:_____Other:_____

Dietary Restrictions: (Food Allergies, Etc.) _____

Treatment History

Are you currently under the care of a therapist/psychiatrist/psychologist/counselor/life coach? Yes _____ No_____

Are you currently taking part in any 12 step programs? If so, please list all:_____

_____

Are you currently under the care of a Physician for any major medical conditions? _____Yes _____No

If Yes: Dr's Name: _____ Phone: _____ Fax: _____

Email: _____ Illness:_____

Circle all types of Therapy and Treatments have you participated in (PHP, IOP, Residential, Psychotherapy, EMDR, DBT, SE, other/ name:_____

Are you currently on any medication? If yes, please list below: _____

_____

Please let us know a little about what you hope to get out of this experience:_____

_____

_____

What was the first trauma or perceived trauma that you experienced?_____

_____ Age?_____

Did you experience other traumatic events? If yes please describe:_____

_____

_____

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How do you cope with your emotions? _____

_____

_____

Have you ever felt suicidal? ___Yes or ___No If Yes, please describe: _____

_____

_____

Do you feel suicidal currently? ___Yes or ___No If Yes, please describe:_____

_____

_____

Are you currently using drugs or alcohol?_____ If Yes, please describe: _____

_____

Please tell us anything else you would like us to know and feel free to type or write anything on an additional page:

_____

_____

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How did you hear about Spirit to Spirit? _____

If referred by a professional, please provide us with their name and telephone # or email:_____

_____

Cost is: $1195.00 per Module

Payment Information - Please Check One Of The Following

○ MasterCard ○ VISA ○ AMERICAN EXPRESS ○ DISCOVER CARD

Name On Card:_____

Card #:_____ Card Code:_____

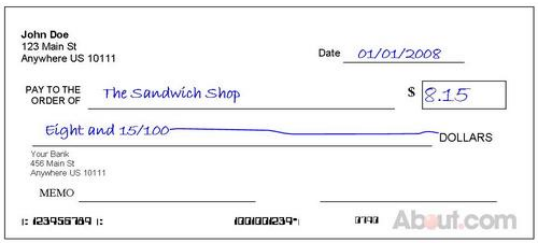
Exp. Date:_____ Amount to be Charged: $_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Cardholders Signature:_____ Date:_____

○



CK #: _____ Amount: $_____

Please Make Checks Payable To: Spirit2Spirit Healing,

Mail to: The Guest House Ocala
Attn: Linda Crane/Spirit2Spirit Healing
PO Box 190, Silver Springs, FL 34488

Fax Application to: 575.613.7167