

SPIRIT 2 SPIRIT

— Healing —

Name: _____

Final Application

*****Circle Appropriate Credential**

Certified Trauma Therapist (CTT®)

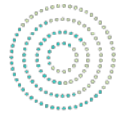
Certified Trauma Professional (CTP®)

Spirit2Spirit

Fax: 575.613.7167

This Form Must Be Filled Out In Its Entirety and Turned In With All Required Supporting Documentation Prior To Final Certification Award

Please Fill Out The Information Below As You Would Like It To Appear On Your Certificate



Contact Information

Full Name: _____

Credentials: _____

SSN: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address _____

Education:

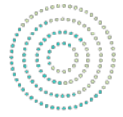
Have You Obtained Any Degrees Since You Began Certification Training? _____ Yes _____ No

If Yes, Please Provide Information Below:

Current Level of Education:

Bachelor's Degree Master's Degree MD PhD Other

Academic Institution	Date of Graduation	Degree Earned



New Certifications (Professional & Job Related):

Certifications Turned Into Spirit2Spirit for Certification Purposes Must Be Current

Certifications Held	Date of Certification

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

License Held	State	License Number

Ethical Violations/Malpractice Claims

Have you had any NEW complaints, grievances, suspensions, revocations or actions filed against you for any reason as a professional, by ANY licensing, regulatory or associative body since beginning this training process?

_____ No _____ Yes (If Yes, Please Attach A Summary of the Details, and Copies of Relevant Information)

Supervision

If You Currently Receive Any Form of Job Related Supervision, Other Than The Supervision Required For This Certification, Please Fill Out Information Below

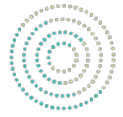
Supervisors Name: _____

Address: _____

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

Phone: _____

Email: _____



Training Supervision

I Successfully Completed 20 Hours of Clinical Supervision With A Spirit2Spirit Approved CTT®/CTP® Supervisor

_____ Yes _____ No

Supervisors Name _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Required Training

<input type="checkbox"/>	I Successfully Completed Module 1 Training & Passed Module 1 Exam
<input type="checkbox"/>	I Successfully Completed Module 2 Training & Passed Module 2 Exam
<input type="checkbox"/>	I Successfully Completed Module 3 Training & Passed Module 3 Exam
<input type="checkbox"/>	I Successfully Completed Module 4 Training & Passed Module 4 Exam
<input type="checkbox"/>	I Successfully Completed Module 5 Training & Passed Module 5 Exam

Required Documentation

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

- Completed & Signed Final Application
- Signed Spirit2Spirit Ethics Statement
- Copies of Any New Diplomas/Certifications/Licenses
- Copies Of Current Resume/Curriculum Vitae
- Copy of Current Malpractice Insurance (CTT® Only)
- Letter Of Recommendation From Your Spirit2Spirit Supervisor Along With A Copy Of All Required Documentation From Your 20 Hours of Required Mentoring

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 and that I will abide by all legal, ethical and generally accepted professional standards including, but not limited to, those outlined in the Spirit2Spirit Ethics Statement.

Signature

Date

Print Name