INSTITUTE OF CERTIFIED
ADHD PROFESSIONALS

Application for ADHD Certified Clinical Services Provider (ADHD-CCSP)

Date:

Name:____
Address:____
City/State/Zip/Country:____
Phone:(_______)____
Email Address:____

I attest to the following (please initial each):

____My professional license is current

____My professional license is in good standing as outlined in Criterion B of the Certification Requirements

____I am covered by current malpractice insurance (individual or under an agency) that meets or exceeds the requirements as outlined in Criterion B of the Certification Requirements

____I have completed the required 24 education hours of ADHD Assessment and Treatment, 3 education hours of Introductory Psychopharmacology and 3 education hours in Educational Management of ADHD.

____I have conducted at least 200 contact hours with ADHD-diagnosed clients, with the use of weekly consultation and/or supervision.

I verify that this application is complete, accurate, and that the information provided and attested to is factual and true. I understand that if any of the information provided and attested to is false or found to be false, my certification will be denied and/or revoked, and my licensing board may be contacted. I understand that information submitted with this application may be verified for accuracy by the Institute of Certified ADHD Professionals. I also agree to contact the Institute of Certified ADHD Professionals in the event that I no longer meet the requirements to be a certified ADHD Clinical Services Provider.

Signed:

Date: