Application for Certified Clinical Anxiety Treatment Professional - Child & Adolescent (CCATP-CA)

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 have completed the required 12 education hours of Anxiety education

____I have conducted at least 150 contact hours with anxiety-diagnosed children & adolescents under the age of 18.

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 Anxiety Treatment Professionals. I also agree to contact the Institute of Certified Anxiety Treatment Professionals in the event that I no longer meet the requirements to be a Certified Clinical Anxiety Treatment Provider.

Signed:

Date: