**WELS / ELS CHRISTIAN THERAPIST NETWORK**

**APPLICATION**

Application date: _____________

**Application status:**

_____ Full Member (Licensed Professionals)

_____ Associate Member (Coach, Staff Ministers, Student in Therapist Training , etc.)

**PERSONAL**

Name: _______________________________________________________________
First Middle Last

Street: ____________________________________________________________

City / State: ____________________________________________ Zip: __________

Home Phone: ___________________________ Cell phone: ___________________

Permanent Address (if different from above):

______________________________________________________________________

City / State: ______________ Zip: __________ Phone number: __________________

Date of birth (month/day/year): _______/______/______ Gender: __ M __ F

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

Ethnicity: (optional) __ Asian or Pacific Island __ African American __ Native American

__ Latin American __ Caucasian __ Other:___________________________________

**PROFESSIONAL**

Self Employed? ___ yes ___ no

Current Employer/Business Name: _______________________________

Business Address: _____________________________ City: ___________________

State: ______________ Zip code: _____________ Phone: __________________

Years worked at current employer: ________ Capacity: _________________________

Office Web site: ____________________________________

**BEST MEANS OF COMMUNICATION:**

How would you prefer the NETWORK to communicate with you in the future?

Personal e-mail:__________________________________

Business e-mail:__________________________________

## EDUCATIONAL EXPERIENCE

### Graduate School(s)

Academic institution: ______________________________________________________

Address: ________________________________________________________________

Highest degree attained: ______________________________________________

Years attended: __________ Course of Study: ____________________________

Minor field of study: _____________________________________________________

Academic institution: ____________________________________________________

Address: __________________________________________________________________

Highest degree attained: ______________________________________________

Years attended: __________ Course of Study: ____________________________

Minor field of study: _____________________________________________________

### Undergraduate Colleges/Universities

Academic institution: ____________________________________________________

Address: __________________________________________________________________

Highest degree attained: ______________________________________________

Years attended: __________ Course of Study: ____________________________

Minor field of study: _____________________________________________________

Academic institution: ____________________________________________________

Address: __________________________________________________________________

Highest degree attained: ______________________________________________

Years attended: __________ Course of Study: ____________________________

Minor field of study: _____________________________________________________

## CURRENT LICENSES / CERTIFICATIONS

License/Certification: ___________________ Number: ____________ State: ____

Date granted: _______________ End date: ___________________

License/Certification: ___________________ Number: ____________ State: ____

Date granted: _______________ End date: ___________________

License/Certification: ___________________ Number: _____________ State: ____

Date granted: ________________ End date: ___________________

If student or not licensed/certified, when do you expect to be licensed/certified? ______

What will the license be in? ___________________________________________

Have you ever had your license/certification revoked or suspended: (If so, please identify the details and action that occurred):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**PROFESSIONAL LIABILITY INSURANCE**

Company name: __________________________________

Address: ____________________________________________________________

Phone: ____________________ Policy number: ____________________

Limits: Per incident: _________ Aggregate: _______________________

Coverage dates: _____________________________________

**CHURCH AFFILIATION**:

Church Name: _____________________________________ Synod: ______________

Address: __________________________________________ Phone: ________________

Pastor(s) Name(s): _______________________________________

_______________________________________

**PROFESSIONAL ORGANIZATIONS**

Professional organizations to which you belong:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**SPECIALIZATIONS / CERTIFICATIONS:**

Please list “specializations”. These are areas of counseling where you have received advanced, specialized training including supervision so that you would be recognized by OTHERS as a “specialist” in this area.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**Please check the counseling areas in which you commonly provide services:**

_____ Abuse / Addiction (alcohol, drug, food, gambling, porn, spending, sex, etc.)

_____ Adolescent Therapy

_____ “Adult survivor” (childhood sexual assault)

_____ Bible based /Christ centered Counseling

_____ Care-giver Burnout

_____ Child Therapy

_____ Chronic Pain / Disease Management

_____ Cognitive Behavioral Therapy

_____ DBT

_____ Dealing with Crisis

_____ Death and Dying

_____ Dissociative Disorder

_____ Divorce Adjustment

_____ Divorce / Separation

_____ Domestic Violence

_____ Eating Disordered behaviors

_____ Elder Care / Geriatric

_____ Employment Issues / Co-worker conflicts

_____ End of Life Issues

_____ Evaluation for clinical depression / anxiety disorders

_____ Extended Family Issues

_____ Faith related questions / doubts impacting mental health

_____ Family of Origin Issues

_____ Grief / Loss

_____ Identity / Self Image Issues

_____ Job Burnout

_____ Job Loss / Career challenges

_____ Learning Challenges, ADD / ADHD

_____ Life Coaching

_____ Marital / Partner Relational Issues

_____ Obesity / Weight Management

_____ Obsessive Compulsive Disorder

_____ Obsessive Compulsive Personality

_____ Play Therapy

_____ Parenting

_____ Personality Disorders

_____ Phobias

_____ PTSD

_____ Rape / Sexual Assault

_____ School Adjustment

_____ Sex Offender Treatment

_____ Sexual Dysfunction

____ Social Phobia

____ Social Skills Training

____ Suicide Survivor

____ Stress reduction / management

____ Terminal Illness

____ Time Management / Priority setting\

____ Transition / Change Issues

**INSURANCE**

Please provide list of insurance companies / managed care organizations and EAPs for which you an in-network provider: ____________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**REFERENCES**

Include 1 pastoral reference and 2 professional references. One professional reference must be familiar with how you use truths from God's Word in your work.

Name: ________________________________
Address: ______________________________
Phone: ______________________________
Years known: ___ What capacity: _______________

Name: ________________________________
Address: ______________________________
Phone: ______________________________
Years known: ___ What capacity: _______________

Name: ________________________________
Address: ______________________________
Phone: ______________________________
Years known: ___ What capacity: _______________

**OTHER**

How did you learn of the Network of Therapists?

______________________________________________________________________________

How do you hope your participation in this network of professional WELS / ELS therapists to be of benefit…

… to you as a professional therapist?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

… to your clients?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

… to the pastors and teachers who refer to you?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

… to other members of the network?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Describe three (3) ways that you commonly integrate Christ-centered, Bible -based truths into your current counseling practice:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Would you be willing to further your education and enhance your skills (and add to your credentials) through completion of the training course entitled "**Guide Me with Your Counse**l"? (Please review brochure included) ___ yes ___ no

What other training are you be interested in receiving? Please list topics, speakers, etc.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please share information about other WELS / ELS professional therapists (licensed or not yet licensed) that would be interested in receiving information about this Network. (Please include full name, address, phone, and e-mail, and the best way to contact them.)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I give my permission to the Membership Committee of the WELS / ELS Christian Therapist Network to contact the above references.

Applicant________________________________

Date____________________________________