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

Date: _____

Name (as it appears on your license):_____

Mailing Address:_____

City/State/Zip/Country:_____

Phone: _____

Email Address:_____

I attest to the following (please initial each):

____I am a State or Nationally licensed (or equivalent outside the U.S.) professional as outlined in Criterion 1.1 of the Certification Standards

____My professional license is current and in good standing as outlined in Criterion 1.2 of the Certification Standards

____I am covered by current malpractice insurance (individual or under an agency) that meets or exceeds the requirements as outlined in Criterion 1.2 of the Certification Standards

____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 as outlined in Criterion 2.1 of the Certification Standards

____I have conducted at least 200 clinical contact hours with ADHD-diagnosed clients, with the use of weekly consultation and/or supervision as outlined in Criterion 3.0 of the Certification Standards

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 if I no longer meet the requirements to be a Certified ADHD Clinical Services Provider.

Signed: _____ Date: _____