Application for Certified Depression & Mood Disorders Treatment Professional (CDMDTP)

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 Depressive & Mood Disorders Assessment and Treatment education and 3 education hours of suicide assessment, prevention and intervention approaches.

____I have conducted at least 200 contact hours with depressive or mood disorder diagnosed clients.

Please submit the required documentation via email to info@icdtp.com

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 Depression Treatment Professionals. I also agree to contact the Institute of Certified Depression Treatment Professionals in the event I no longer meet the requirements to be a Certified Clinical Depression & Mood Disorder Treatment Provider.

Signed: _____ Date: _____