



Application for Certified Advanced Grief Counseling Specialist (CAGCS)

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 have completed the required 18 education hours as outlined in Criterion 2.1 of the Certification Standards

____ I have conducted at least 200 clinical contact hours with grief clients as outlined in Criterion 3.0 of the Certification Standards

____ I have had a licensed professional peer complete a letter of recommendation 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 Evergreen Certifications. I also agree to contact Evergreen Certifications if I no longer meet the requirements to be a Certified Advanced Grief Counseling Specialist.

Signed: _____ Date: _____

Letter of Recommendation

(To Be Completed by a Licensed Professional Peer of the Applicant)

Date: _____

Name (as it appears on your license): _____

Profession and License Number: _____

Letter Attesting to the Applicant’s Grief Work:

Signed: _____ Date: _____