



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 the Evergreen Certifications Code of Ethics

____ 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 professional 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: _____

Professional Recommendation

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

Date: _____

Name (as it appears on your license): _____

Profession and License Number: _____

How long have you known the Applicant? _____

Based on your assessment of the Applicant's professional capabilities, is this Applicant proficiently skilled in the following categories?

	Yes	No
Solid knowledge of Grief Counseling		
Utilization of Grief Counseling in clinical practice		
Sound clinical judgement		
Professional integrity		
Appropriate boundaries		
Ethical conduct		

Would you refer clients to this Applicant for grief counseling?

_____ Yes

_____ No

Signed: _____ Date: _____